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From Normality to Risk:

A qualitative exploration of health visiting and mothering
practices following the implementation of
Health for All Children

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PhD Population Health Sciences
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Declaration

I, Caroline Anne King, declare that the following thesis has been composed by me and has not been submitted for any other degree or professional qualification.

Caroline Anne King

.....

Date

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As soon as one can no longer think things
as one formerly thought them,
transformation becomes
both very urgent, very difficult,
and quite possible.

(Foucault 1988, 155)

Abstract

The overall aim of this study is to explore how health visiting and mothering practices have been shaped by the implementation of Health for All Children (Hall). 'Hall' denotes a programme of work around child health surveillance and promotion published in four reports between 1989 and 2003. The fourth Hall report (Hall 4) marked a shift towards a more targeted approach to service provision, predominantly through the work of health visitors, yet aimed to meet the needs of all families with young children. The study explores how health visitors' work practices have been shaped by this new policy context, including how it has influenced their relationships with families as well as the profession as a whole. It also examines the experiences of mothers, their relationships with health visitors, and how they negotiate and manage their children's health and well-being.

A review of Scottish policy reveals an early years agenda focused on risk and early intervention; and that community nursing has been at the centre of, and shown resistance to, a number of policy directives over the last decade. A review of the existing literature explores the relationship between evidence and Hall and identifies health visitors as the profession charged with its implementation. Literature on mothering and fathering exposes a focus on parenting in policy which belies the gendered nature of caring for children. The empirical study reported in this thesis is located theoretically in relation to the shifting emphasis in disciplinary practices shaping child health from normality to risk.

The study uses a qualitative approach and took place within the Lothian region of Scotland. Initially, discussions with policy-makers and practitioners working in the early years, nationally and locally, were carried out to scope the context for the study. Semi-structured interviews with 16 health visitors and 20 mothers were then undertaken and analysed thematically, with the findings chapters shaped through an iteration between theory and grounded analysis of the accounts of the health visitors and mothers.

The health visitors' accounts reveal the changing nature and form of their knowledge and expertise and the implications of this for their practice and profession. The discussions of health visiting practice identify the important roles of observation and relationships work

with families, in homes and clinics over time, and how these activities enable health visitors to construct knowledge of families. The interviews with mothers suggest a blurring between lay and professional knowledge where normality is defined by mothers themselves and through their relationships with health visitors. While the mothers work to construct themselves as morally adequate, attention to the stories mothers tell, and, in particular, the emotion in them, suggests that vulnerability can be experienced by any mother. This phenomenon sits in contrast to increasing attention by professionals placed on the monitoring and policing of 'vulnerable' families while opportunities for observation and relationships work diminish. The study concludes by exploring key conceptual issues. It considers shifts between normality and risk and how these are shaping how vulnerability is constituted through health visiting practice. In conjunction, it explores the implications of changing health visiting practices, for health visitors, as a profession. Finally, the scope for the health visiting profession to shape policy and practice are considered.

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Chapter 1: Introduction

1.0 Aim of the study

The overall aim of this study is to explore how health visiting and mothering practices have been shaped by the implementation of Health for All Children (4th edition, 2003) (Hall 4¹). Hall 4, published in 2003, marked a shift towards a more targeted approach to service provision, predominantly through the work of health visitors, yet aimed to meet the needs of all families with young children.

1.1 Background to the study

The study was initiated through a partnership between NHS Lothian and the Centre for Research on Families and Relationships (CRFR). It was funded by an Economic and Social Research Council (ESRC) CASE studentship. Hall 4 was identified by NHS Lothian as a policy which would bring about substantive changes to how services for families with young children were provided. The NHS Lothian and CRFR partnership allowed for the development of a study to explore the practice implications of the policy shift and the impact that it would have on families with young children.

The study started with a focus on gaining insight into the experiences of health professionals as service providers and parents as service users. As the study developed, ‘health visiting work’ became the central focus and the key to unlocking other areas of understanding about how Hall 4 had impacted on both the professional groups providing services and the families receiving them. At the same time, the mothers’ accounts became central to understandings of vulnerability. While more space is given to the health visitors’ accounts in the reporting of the findings, the analytical ‘story’ of the PhD would not be possible without the mothers’ accounts. Thus, value is given to *all* the accounts in the telling of the analytical story.

¹ My use of the acronyms ‘Hall’ and ‘Hall 4’ reflects the terms most commonly by respondents during the fieldwork for this study. Since the completion of the fieldwork, ‘Health for All Children’ has replaced the use of these acronyms in some policy and practice communities (McKenzie, G. 2012).

Discussions with policy-makers² working in the early years, nationally and locally, were carried out to scope the context for the study. These discussions with policy-makers, as well as setting the context for the study, highlighted to me that Hall 4 is about people and institutions. It is through the interactions between them, and the sharing of knowledge and expertise, that the four published documents have been generated as a (one over another possible) record. The role of the policy-makers in scoping the context of the study recognised them as ‘expert’ witnesses to the processes of policy formation and practice development over research subjects. The position of the policy-makers within the research process has implications of ‘extrinsic’ (Hammersley and Traianou 2012) ethical concern around informed consent, the use of verbatim quotes and ‘deductive disclosure’ (O’Reilly, Karim et al. 2012) which I consider in this thesis.

My own interest in researching the topic of Hall 4 came from my previous professional work as a nurse, in health promotion, and as a researcher. As a researcher with Save the Children I was involved in policy related research which had been commissioned in response to existing policy agendas. This PhD study, for me, has been an opportunity to explore analytically a key area of policy bringing my interests in health, the early years and the nursing profession together. I saw the opportunity to explore social theory as a key to greater understanding of the relationships between research, policy and practice, where, as Foucault (1988:155) suggests:

As soon as one can no longer think things as one formerly thought them, transformation becomes both very urgent, very difficult and quite possible.

The empirical data in the thesis are based on the accounts of 16 health visitors and 20 mothers. I have taken a feminist approach to the research. I recognise that Hall 4 and the recommendations made for practice have gendered implications. The majority of health visitors are female, working with, predominantly, mothers. Hence, it is the accounts of the health visitors and the mothers which I have chosen to foreground in order to reveal these gendered impacts. I recognise this thesis to be one of many analytical stories that could be told about Hall 4. In line with this position, I explore the methodological issues in constructing my sample and what this means can be said and what cannot.

² The majority of the policy-makers also had a practice remit.

A 'systematic' and 'selective' review of studies was carried out by Elkan, Kendrick and colleagues for the NHS R & D Health Technology Assessment in 2000. Their remit was to review the effectiveness of domiciliary health visiting. There is also a published literature in response to this review and, more broadly, around evidence-base and the health visiting profession. This literature provides a benchmark of thinking around evidence-based practice which I use to explore the findings of this study. In conjunction, the dearth of published literature on child protection and health visiting practice is a puzzling absence. This lack cannot be explained solely, I believe, as has been suggested, as child protection work being the remit of other institutions and professional groups such as social services and social workers (Cowley, Mitcheson et al. 2004), or social work departments in Scotland. This literature, and the absences revealed within it, set the context of this study and point it towards an analytical gap in the existing evidence that this thesis explores. Of note also, is the wider policy context within which this study of Hall has taken place. This includes a focus on risk in early years policy and the presence of professional resistance to changes proposed for community nursing.

1.2 Outline of the thesis

In Chapter 2 the development of Hall and its implementation in Scotland are reviewed. In conjunction, a review of Scottish policy reveals an early years agenda focused on risk and early intervention; and that community nursing has been at the centre of, and shown resistance to, a number of policy directives over the last decade. In Chapter 3 a review of the literature generated just prior to and since the publication of the first Health for All Children report (from 1985 to 2011/12) explores the relationship between evidence-base and Hall and identifies health visitors as the profession charged with its implementation. Literature on mothering and fathering exposes a focus on parenting in policy which belies the gendered nature of caring for children. The empirical study reported in this thesis is located theoretically in relation to the shifting emphasis in disciplinary practices shaping child health, from normality to risk. In Chapter 4 the research approach taken in the study is outlined and considered through exploring the ethical and methodological issues presented in researching a topic relevant to policy and practice.

My findings, which are shaped through iteration between theory and grounded analysis, are presented in Chapters 5 to 8. In Chapter 5, the health visitors' accounts reveal the changing nature and form of their knowledge and expertise and the implications of this for their practice and profession. In Chapter 6, discussions of health visiting practice identify the important role of observation and relationship work with families, in homes and clinics over time, and how this enables health visitors to construct knowledge of families. In Chapter 7, the interviews with mothers suggest a blurring between lay and professional knowledge where normality is defined by mothers themselves and through their relationships with health visitors. While the mothers work to construct themselves as morally adequate, attention to the stories mothers tell, and, in particular, the emotion in them, suggest that vulnerability can be experienced by any mother. In Chapter 8, I return to the health visitors' accounts to explore how mothers' experiences sit in contrast to increasing attention by professionals on the monitoring and policing of 'vulnerable' families, while opportunities for observation and relationship work diminish. The study conclusions are discussed in Chapter 9. The study concludes considering shifts between normality and risk and how these are shaping how vulnerability is constituted through health visiting practice. In conjunction, it explores the implications of changing health visiting practices, for health visitors, as a profession. Finally, the scope for the health visiting profession to shape policy and practice are considered.

Chapter 2: Policy Context

2.0 Introduction

The aim of this chapter is to mark out the policy terrain which has informed and which contextualises this study of the implementation of Hall 4 in a particular area in Scotland. First, I consider the development of Health for All Children (Hall) in a UK context and its implementation in Scotland, with a brief outline of how this has diverged from its implementation in England. I then contextualise and situate the study by examining the policies relating to the early years agenda and the community nursing workforce in Scotland. The chapter draws on published policy documents and related published literature, for example, website information, working group minutes over the decade around when Hall was published in 2003, moving back to devolution in 1999 and forward to contextualise the study in recent policy development in Scotland. The fieldwork for the study took place in 2007 and 2008. The mapping of the early years policy landscape which underpins this chapter was informed by the scoping interviews, all of which took place in 2007. The policies and emphases within these policies that are discussed in this chapter reflect the wider themes of the thesis. It considers how risk has become a focus of policy on the early years and the role of professional resistance in shaping the community nursing agenda. The chapter also aims to explore how the framing of some groups as vulnerable, for example, through targeted interventions, may enable implicit political goals around improving child health through early intervention to be achieved, while doing little to address their stated objectives around addressing health inequalities.

2.1 Health for All Children (Hall)

2.1.1 The Hall reports

Health for All Children and the acronym 'Hall' are terms which are widely recognised by health professionals working with children and their families in the United Kingdom (UK). Hall has become synonymous with health visiting practice around child health surveillance and promotion and is a term widely used in policy and research reports. Hall is a relatively contemporary phenomenon which can be traced back to the mid-1980s when a working

group with members, predominantly from the medical profession, and a chair, appointed through the British Paediatric Association³, was convened. The remit of the group as outlined in the first Hall report was:

To review and comment upon current practice in child health surveillance in the United Kingdom and to make recommendations for future practice (Hall 1989).

The work of this group resulted in a set of recommendations which focused on the practices of the medical profession, published in 1989 (Hall 1989). Two subsequent reports were published in 1991 (Hall 1991) and 1996 (Hall 1996). The fourth Hall report (Hall 4) was published in 2003 (Hall and Elliman 2003), with a version including additional information on policy and research developments since 2003 published in 2006 (Hall and Elliman 2006). Like the first report, the content and recommendations of each of the subsequent reports has been formulated through a programme of working group meetings and editorial processes. The remit of the working groups, the diversity of the professional groups involved and the nature of their input is reported differently in each report and reflects wider shifts in the relationships between the professional groups involved. The second report has a slight, although not substantial, shift in orientation. The chair of this group was a General Practitioner (GP) reflecting a shift in focus, at that time, of professional practice around child health development from the hospital to the community (Kirk and Glendinning 1998). While this is the case, the continued involvement of hospital paediatricians in community health care ensures that their influence remains central to the process. In the third Hall report, published in 1996, the shift in focus began to move away from screening to detect developmental difficulties and delays, and was placed instead on the promotion of health and development. In this report, the increased prominence of neuroscience and social sciences research reflects developments around the use of an evidence-base to influence the practices of health professionals and through doing so to meet political aims around the nation's health through the health of our children and families (Armstrong 1995; Rose 2001). An emphasis on neuroscience and social science, in tandem, focuses child development on the brain and gives recognition to the wider social factors affecting children's health and their development at the same time. In the fourth Hall report (Hall 4), and in the updated version published in 2006, Hall and Elliman (2003, 2006: Preface)

³ The British Paediatric Association became the Royal College of Paediatrics in 1996.

emphasise that the report reflects a ‘gradual shift from a highly medical model of screening for disorders to a greater emphasis on health promotion, primary prevention and active intervention for children at risk, whether for medical or social reasons’. This report saw a focus on risk, which had been present but peripheral in 1996, brought centre stage. At the same time, the publication of Hall 4, and the recommendations to shift away from routine child development checks to a more targeted service, galvanised an existing debate contributed to by many, including academics, policy-makers and those in the health professions, about whether health visiting services should be provided universally to all families or targeted to some families over others. Analysis of the ideological shifts within the welfare state from post-war to the beginning of the 21st century, those which suggest the ‘end of a systematic welfare state’ where ‘new patterns of risk and postmodern cultural formations are supporting eclectic policy making which is more in tune with cultural majorities’, provide context and fuel for these discussions (Baldock 1999:458).

2.1.2 The policy context of Hall 4 implementation

Hall 4 was developed, influenced and endorsed, to varying degrees, by a range of professional groups, including medicine and community nursing. Its relevance to the service provision of all four nations of the United Kingdom has been shaped by the particular political and policy contexts of each country. In England the ‘National Service Framework for Children, Young People and Maternity Services’ (Department of Health 2004) has been followed by the Healthy Child Programme (Department of Health 2009). In Scotland, implementation of the framework was guided by ‘Health for All Children 4: Guidance on Implementation in Scotland’ (Scottish Executive 2005a). This guidance has been followed by three policy documents aimed at influencing the implementation of Hall 4 in Scotland at a local level:

- Chief Executive Letter (CEL) ‘Refresh of Health for All Children (Hall 4) – Reinforcing the Key Messages’ (Scottish Government 2010a)
- ‘A New Look at Hall 4: The Early Years Good Health For Every Child’ (Scottish Government 2011a)
- ‘The Scottish Child Health Programme: Guidance on the 24-30 month child health review’ (Scottish Government 2012a).

2.1.3 Context of the implementation of Hall 4 in Scotland: Starting Well

In Scotland, as in the other nations of the UK, there have been a number of developments in policy in relation to community nursing and the early years which have taken place over the last decade and which provide important context to this study. These have impacted on how Hall 4 has been adopted into practice. At the same time, the effects of Hall 4 on professional practice have impacted on how other policies have been received by practitioners (Pollock 2009).

Preceding Hall 4, 'Starting Well, a Scottish Demonstration Project' was funded by the Scottish Executive (now Scottish Government⁴). Its aim was:

... to demonstrate that child health in Glasgow can be improved by a programme of activities that both supports families and provides them with access to enhanced community-based resources (Scottish Government 2006).

This project was part of an emerging body of work, influenced by American studies by David Olds, which focused on early years interventions as a mechanism to break into cycles of deprivation. This principle is demonstrated by MacKenzie and colleagues (2004) in an evaluation of Phase 1 of Starting Well, who highlight:

A key part of the rationale for this investment was the widespread belief that 'early years' interventions can help to break the cycle of poverty that limits the opportunities available to children born into the most disadvantaged circumstances (Mackenzie, Shute et al. 2004).

The project was awarded £3 million funding, in 2000, for a three-year period. The evaluation of the study concluded that in relation to the process and child health related outcomes measured, 'it is clear that Starting Well did not, for example, demonstrate the step change that it aspired to as measured by the most important health related outcome that we investigated, and nor did the process of service development and delivery run as smoothly as predicted' (Mackenzie, Shute et al. 2004). The project evaluation highlighted a number of policy implications around the complexity of implementing and evaluating evidence-based practice and achieving change within organisations and professions. A desire to prove

⁴ The executive arm of the devolved government in Scotland was known as the Scottish Executive from its formation in 1999 until 2007 when it was renamed the Scottish Government by the Scottish Nationalist Party (SNP) minority government.

effectiveness by those involved in the intervention, at a strategic level in particular, is evident in the evaluation report. However, the report tells a stark story of health visitor resistance to attempts to standardise their practice. Tensions between targeted interventions and universal services are also in evidence, for example, in relation to the difficulties experienced with attempts to integrate the targeted intervention with universal services (Mackenzie, Shute et al. 2004).

The Scottish Government information about Starting Well published on their website (Scottish Government 2006) promotes the use of multi-disciplinary teams to meet the ‘needs of the most vulnerable children’. It proposes that the work would be extended across Glasgow in 2006 and that it, ‘has been developed in the context of the national implementation of Hall 4 guidance, which places emphasis on targeting of interventions for children and families at risk’, with PACT (multi-agency teams to work with parents and children from health, social work, voluntary sector and education) teams in Glasgow and national learning being the legacies of the project (Scottish Government 2006). The evaluation suggests that the initial aims of Starting Well were ambitious and that the final outcomes were both far more meagre and, the evaluation would suggest, complicated (Mackenzie, Shute et al. 2004). The project did, however, provide the Scottish Government, and others involved in the delivery of child health services, with a template for targeted services not previously available. Findings from the project, published since, suggested that targeting support to families in the early weeks after a baby is born would not correctly identify the most vulnerable families (Wright, Jeffrey et al. 2009). These published findings have since been used widely by those engaging in the debate around targeted and universal services (Appleton 2011; Condon 2011a; Bellman and Vijeratnam 2012).

2.1.4 The implementation of Hall 4 in Scotland

The implementation of Hall 4 in Scotland was initiated in 2005 with the publication of ‘Health for All Children 4: Guidance on Implementation in Scotland’ (Scottish Executive 2005a). This report was produced from the work of a multi-disciplinary group of professionals, named the Child Health Support Group Hall 4 Reference Group, which was chaired by Dr. Zoe Dunhill, a consultant paediatrician. The publication of the Scottish

Guidance followed a consultation on Draft Guidance carried out in 2005 (Reid-Howie-Associates 2005). The consultation findings suggested that health visitors were reticent about the changes being suggested for their practice. Through the consultation they highlighted the complexity of vulnerability and parent/professional relationships which a targeted response would not necessarily, they felt, address (Reid-Howie-Associates 2005). The document focused on the process of ‘needs assessment’ and a programme of child health where each child would be given a Health Plan Indicator (HPI) through which they would receive one of three trajectories of care: the Universal Core Programme with no additional input (Core); the Universal Core Programme with additional input (Additional); or the Universal Core Programme with intensive input (Intensive). Research carried out in Scotland since, by Hogg and colleagues (forthcoming), has indicated that the programme has been largely driven by resource over need. Their findings identified measures taken by health visitors to manage their caseloads, such as allocating families to a Core HPI when resources were not available to meet additional needs. In addition, they found that it was families who were allocated an Intensive HPI who shaped the concerns of managers in decisions about workload allocation. A study by Wood and colleagues (2012) has also revealed that since the implementation of Hall 4 in Scotland the uptake of universal child health reviews has remained the same. They found that the uptake was lower for children living in the most deprived areas both before and since Hall 4. The authors suggest that changes to child health services since Hall 4 are unlikely to be impacting on the health inequalities agenda while this is the case. They believe that the equitable uptake of reviews, not evident in current health data, will be necessary to achieve this goal (Wood, Stirling et al. 2012).

The time period since the publication of the Scottish guidance has seen a number of policy orientated developments aimed at directing the implementation of Hall 4 in Scotland. In 2010, a Chief Executive Letter (CEL) was issued to all Scottish Health Boards which reemphasised their responsibilities in relation to the implementation of Hall 4. ‘A New Look at Hall 4: The Early Years Good Health: Health for Every Child’ was published in 2011. This was the Scottish Government’s response to concerns raised, through practitioner and practice communities, about how Hall 4 was affecting professional practice, with its

consequent impact on children's health and well-being (Garvie 2011). It reformulates the HPIs into two categories of Core and Additional, reintroduces a 24-30 month review for all families and emphasises the importance of health improvement information and advice. The document identifies these as the three main aspects identified through consultation, leaving the detail of implementation to local health boards and practitioners. Relevant to this approach to implementation at a local level is research which was carried out in England after the publication of Hall 4 (Condon 2008; Condon 2011a). It examined the relationship between policy directives and health visiting practice and revealed the complexities and difficulties inherent in the process of translating policy at a local level (Condon 2008).

This said (the devolving of responsibility to local level in 'A New Look at Hall 4'), in May 2012 the Scottish Government published, for consultation, 'The Scottish Child Health Programme: Guidance on the 24-30 month child health review' (Scottish Government 2012a). In providing guidance for the implementation of the 24-30 month review for all children in Scotland it provides a critical consideration of issues around professional judgement and the use of assessment tools and the systematic collection of data about children's health. Importantly, however, it states that no additional resources are available centrally for local implementation of the programme.

2.2 Context: The early years agenda in Scotland

2.2.1 Stating the case for a focus on the early years

The case for the need to focus on the early years of children's lives to impact on health inequalities has been made in the Marmot Review (Marmot 2010:60). The extent and nature of health inequalities in the early years in Scotland using data from Growing up in Scotland has recently been reported on (Bromley and Cunningham-Burley 2010). In England, a review on early intervention called 'Early Intervention: The Next Steps' has been conducted, lead by MP Graham Allen (Allen 2011). In Scotland, a report 'Joining the Dots' by Susan Deacon was published. Through her remit she was asked to, 'be a champion, lead dialogue, build consensus, examine a big and complex issue and draw out suggestions for practical action' to respond to the overarching question of 'what we could do to improve

children's early years in Scotland' (Deacon 2011:6). Together, these indicate a political swell of interest in the early years in England and in Scotland.

2.2.2 Context: The early years agenda in Scotland since 2003

The early years agenda in Scotland has been shaped by a number of interrelated policy developments in the last decade. The publication of Hall 4 and its implementation in Scotland took place at a time when child protection services were centre stage in policy developments. A study by Vincent and colleagues (2007) has shown how an inquiry into the death of Kennedy McFarlane was influential in a review of child protection across Scotland being carried out which culminated in a report being published called 'It's everyone's job to make sure I'm alright', which was followed by a 3-year programme of work called the Child Protection Reform Programme (CPRP). This programme had the stated goal of, 'improving protection of children at risk of neglect and abuse and reducing the number of children who need protection' (Daniel, Vincent et al. 2007:3). The programme of work included a number of outputs, including; child protection standards, guidance, inspection and training, all with a multi-agency focus. The programme was launched in 2003.

Getting it Right for Every Child (GIRFEC) was initiated as a programme of work by the Scottish Government in 2004. Its aim, stated in broad terms, is to, 'improve outcomes for all children and young people in Scotland', with the additional aim of influencing and becoming embedded in 'all existing policy, practice, strategy and legislation affecting children, young people and families' (Scottish Government 2010b:1). GIRFEC followed on from a review of the children's hearings system in 2003 which brought children's services, and their impact on the health and wellbeing of the child, to the attention of policy-makers. Vincent and colleagues (2007) have highlighted that in GIRFEC a very different way of providing children's services was promised:

The "Getting it Right for Every Child" proposals in Scotland claimed to be 'the programme for change that will revolutionise services for children' (Scottish Executive, 2006). These have an emphasis on meeting the needs of all children, removing the distinction between children in need and children in need of protection. They attempt to remove barriers to joined up working and inter and intra agency co-operation (Vincent, Smith et al. 2007:95).

Indeed, they suggest that GIRFEC, ‘attempts to address many of the issues raised by inquiries and reviews (of child deaths) ...’ (Vincent, Smith et al. 2007:95), thus, bringing the child to the centre within child health services and policy orientated to the development of these services.

The Scottish Government has been engaged in an extensive programme of work around GIRFEC demonstrated by the plethora of reports and evaluations aimed at communicating the principles of the programme to diverse service providers, embedding them in their practices and demonstrating their effectiveness. In conjunction, attempts made to analyse and understand risk and risk assessment from the perspectives of multiple professional groups has brought risk centre stage in GIRFEC related documents:

Traditionally, agencies have seen helping a child only in terms of the part of the child’s life that is the concern or responsibility of their agency. *Getting it right for every child* asks all practitioners to think about a child’s problem not only from their agency’s perspective but also to see any risks and needs in the context of the whole of a child’s life (Aldgate and Rose 2009:3).

The difficulty in reaching a consensus over the meaning of vulnerability in this, and other early years policies, has resulted in the social orientated language of risk and the health orientated language of needs becoming fused:

Many of these children, who are not meeting their *Wellbeing Indicators*⁵, will have a complex mix of risks and needs. Indeed, we would argue that risks and needs are two sides of the same coin. If a child is at risk in some way, that child will have needs related to their wellbeing. The more complex and interrelated the risks, the more likely that children’s wellbeing will be affected on several fronts (Aldgate and Rose 2009:2).

At the same time, there have been attempts to find a common language and meanings across agencies:

... risk assessment is used by many agencies but often has been agency specific ... The principles of GIRFEC demand that children and families are at the centre of any process of assessing risk (Aldgate and Rose 2009:29).

An approach using pathfinders, initiatives which focused on problem solving and learning, was used to introduce GIRFEC into practice. Two pathfinders were established. In

⁵ Refers to Scottish Government aim that: Every child needs to be healthy, achieving, nurtured, active, respected, responsible, included and safe. (GIRFEC, Scottish Government 2008a)

Highland, the pathfinder was focused on all child concerns, and in Clydebank, Dumfries and Galloway, Falkirk and Edinburgh a single issue approach on domestic abuse was taken (Watt, Ellison et al. 2011). Evaluation reports from the pathfinders again show eagerness to prove effectiveness through locating examples of ‘good practice’ which have emerged as a result of the implementation of GIRFEC. At the same time, however, they reveal a more complex picture of how GIRFEC has shaped the practices of organisations and professional groups who, although they have a stated common interest in the health and welfare of children, have diverse histories and contemporary practices. Underpinning many of the policy developments, such as GIRFEC, is a discourse around technology and information sharing (most often referred to as ICT). Information sharing between professional groups is often identified as a problem, with the need for improvements in the compatibility of the technological systems used to facilitate this.

2.2.3 Context: The early years agenda in Scotland since 2007

Since 2007, and the election of the SNP minority Government, the early years agenda has continued to be a dominant aspect of policy in Scotland. While this is the case, the extent of the current focus on it is perhaps less than might be expected given the upsurge in both academic and policy interest in the early years in recent years. The Early Years Framework (Scottish Government 2008b) is one of three social policy frameworks published by the Scottish Government, with Equally Well (Scottish Government 2008c) focusing on addressing health inequalities and Achieving Our Potential (Scottish Government 2008d) on tackling poverty. The Scottish Government programme of work relating to the Early Years Framework has followed on from, and taken the place of, Sure Start Scotland. Sure Start Scotland, which started in 1999, focused on integrated services for children and families, which Wood (2009:290) suggests was ‘important in developing and testing innovative ways of integrating services for vulnerable children’. Sure Start Scotland, with its integrated approach, offered the opportunity to (re)shape the traditional boundaries between professionals and their organizations. The Early Years Framework has now become the focus of work through the Scottish Government in place of Sure Start Scotland (Scottish Government 2012b). This aim has been reflected in policy developments since, such as GIRFEC, which have aimed to promote the adoption of a common language and processes

of assessment and working with children and their families between professional groups. The services provided by Sure Start Scotland, while bringing agencies together in new and different ways, also brought into focus questions around service provision, targeting, stigma and conceptualizations of vulnerability (Cunningham-Burley, Carty et al. 2005:ix). The hoped-for beneficial effects of Sure Start were challenged, however, when evaluations of the Sure Start programme in England suggested that while the programme had been accessed by families affected by deprivation, it had not been accessed by the most deprived groups (Belsky, Melhuish et al. 2006).

The Early Years Taskforce, set up in November 2011, accompanied by funding through the Early Years Change Fund, suggests that interagency and collaborative working around the early years remains a central policy goal. Set up by the Scottish Government, membership includes local government, the NHS, police and the voluntary or third sector. Its terms of reference see it as the mechanism for taking forward the agenda set out in the Early Years Framework and set out its priorities as the ‘Early Years [sic] of children’s lives’ and ‘early intervention’ (Scottish Government 2011b:1). The capital letters used in error in the document (quoted above) are an illustration of how the policy agenda is colonizing the early years of children’s lives where the language of policy and the time period in children’s lives have become merged. The language used in the documentation emerging from the Early Years Taskforce around universal and targeted services suggest a recent shift which sees universal services (re)emerge and reconstituted as a means of meeting the needs of vulnerable families:

The Early Years framework acknowledges the power of universal services in securing better outcomes for children is key. However, there is a need to strike the balance between universal and targeted services. The taskforce recognises the importance between universal and targeted services at supporting vulnerable children and their families. While we need to focus provision on where it is needed most, we must also ensure that universal services can deliver effectively for the more vulnerable (Scottish Government 2012c:4).

Similarly, vulnerable families themselves are framed as resistant users of universal services, a barrier which requires the use of strategies to overcome:

... universal services, which cater for all children, must have the capacity and skills to engage all children and families throughout the early years of a child’s life – even

those who may be challenging and reject first offers of help (Scottish Government 2012c:4).

It marks shifts in the provision and ideology of the welfare state where there is an increasing emphasis evident around health (and self) improvement with a focus on individuals (and organizations):

We need to shift the focus from service provision as the main vehicle for delivery of outcomes to building the capacity of individuals, families and communities ... (Scottish Government 2012c:5).

One way in which it is proposed this will be achieved is by working through a National Parenting Strategy which will, 'encourage agencies to work together to support parents and help them to develop their parenting skills' (Scottish Government 2012c:5). This plan is reinforced in the Scottish Government's promotion of the National Parenting Strategy which has as one of its aims to:

Set out a cohesive and compelling narrative around the value and importance of parenting, and how this contributes to our national wellbeing across a range of agendas and indicators (Scottish Government 2012d).

In this way, responsibility for children's early years, now framed through policy processes, is (re)cast to parents.

2.2.4 The Family Nurse Partnership (FNP) and evidence-base

The draw of targeted interventions which focus on a sub-group of the population deemed vulnerable and which have been previously evidenced in a different context for governments has been documented (Wilson 2002; Mitchell and Wilson 2012). This ethos is epitomised in the Family Nurse Partnership (FNP) programme which was developed and researched in the US and which draws heavily on a body of research by David Olds and which also informed the Scottish Government's earlier early intervention programme, Starting Well. The FNP is offered to all first-time teenage mothers. It is currently being piloted in NHS Lothian and NHS Tayside, with a Scottish Government commitment to develop the FNP programme across Scotland (Scottish Government 2012e). It has also been running in England since

2007 where it is being evaluated through a formative evaluation and a randomised controlled trial (RCT).

Whereas Starting Well, which was discussed earlier in this chapter, was promoted as an opportunity for evidence gathering, the FNP is a central aspect of government policy which is viewed as providing a pre-existing evidence-base for practice, albeit gathered from the application of the intervention within different social, cultural and political contexts⁶:

FNP is consistently rated by high quality evidence reviews as one of the most effective preventative programmes for vulnerable young families (Scottish Government 2012e).

The FNP has been supported from within the health visiting profession where health visitors themselves have highlighted it as a potential opportunity for learning for universal services (CPHVA and Unite the Union 2009).

In the information on the Scottish Government website, the FNP is promoted by drawing on an evidence-base from neuroscience. This evidence-base is used to argue for the need for early intervention with specific vulnerable groups:

It is estimated that between 2 and 5% of children in the UK experience multiple deprivation and poor outcomes, incurring high cost to the public purse and society ... Recent neuro-scientific evidence shows how for these children negative experiences and poor parenting in pregnancy and very early childhood can do lasting harm to a child's brain development, behaviour, learning and long term health. There is, therefore, a strong case for intervening early with powerful programmes known to make a difference for these vulnerable children. ... FNP is a preventive programme for vulnerable young first time mothers ... FNP is targeted on teenage first time mothers as a large body of research shows this group have a high level of need and that their children are at high risk of poor outcomes in the future (Scottish Government 2012e).

Imagery around the brain (underlined above) is employed in the communication of the 'neuro-scientific' evidence-base. Likewise, this tactic is commonly used in the communication of neuroscience research within lay and professional groups with reductionist visuals of 'normal' brain development and the comparative brain development

⁶ Indeed, one of the conditions of the licence of the FNP is that its implementation must be accompanied by an RCT.

of a severely neglected child often used in presentations (e.g. Storrie 2010). This portrayal acts powerfully to set up and feed into a dichotomy of those who are vulnerable and those who are not, and to justify this focus.

Vulnerability in mothering, in the FNP, is conceptualised as inherent through the experience of being a first-time and teenage mother. The difference between targeted, well funded programmes of intervention, such as the FNP, and universal services goes unaddressed in these policy documents supporting their implementation. Claims of success draw heavily on the beneficial longer-term impacts for those involved in the intervention. There is little exploration, however, of the longer-term impacts for all families and the future families of the intervention group (those not offered the intervention). It is possible that, while the young mothers who receive the intervention may benefit from it, the stigma experienced by young mothers as a group will remain. From a governmental perspective these programmes offer a high likelihood of success through defining and intervening with a sub-group of the population allowing for them to reach their own political goals. This practice does not require for them to address, however, the demands for a universal service working with the population as a whole. The US FHP research has been heavily used by policy-makers as evidence of the long-term benefits of early intervention (Scottish Government 2012e). This reliance raises questions around how evidence is used to support rather than inform policy making.

The focus of the Scottish Government on the FNP has attracted criticism from various practice communities of, for example, GPs. Their vocal objection to a targeted intervention, which focuses mainly on the health and well-being of a sub-group of the population, through writing to the Scottish Parliament's Finance Committee has been documented (Mackintosh 2011). This response suggests that the debate around universality and targeting continues to be shaped through resistance from within the health professions.

2.3 Context: The community nursing workforce

2.3.1 The focus on community nursing within policy

The community nursing workforce, which is referred to in policy and practice contexts as district nursing, health visiting and school nursing (sometimes also referred to as public health nursing) and family health nursing, has been the focus of a number of Scottish Government policies over the last decade. In 2001, the publication of *Nursing for Health* (Scottish Executive 2001), introduced the idea of different models of community nursing and modes of delivery of care to those in the community. With a notable focus on public health, it challenged the concept of universality and introduced the idea that services should be targeted to need. In response to an increasing awareness of workforce shortages it proposed skill mix and the blending of school nursing and health visiting. Although there has been an awareness of workforce shortages in policy and practice contexts, measuring the health visiting workforce in Scotland has proved problematic, although annual workforce plans are now required from NHS Boards (Scottish Government 2007). In England, following the Government's promise of 4,200 additional health visitors for their workforce, there is greater evidence of analysis in this area (CPHVA and Union 2009; Centre for Workforce Intelligence 2012).

The readiness of the health visiting profession to respond to public health goals was questioned by the authors of the *Starting Well* Evaluation:

The increasing burden on health visitor caseloads and the early lack of clarity in the role of the community support facilitator ... led to the lesser emphasis on advocating for community change within the health visitor role, which questions the assumption that health visitors, and the changing systems with which they work, are ready for the challenges posed by *Nursing for Health* (Scottish Executive, 2001) (Mackenzie, Shute et al. 2004).

Equally, suggestions of skill mix have been met by a broad range of responses. This includes research exploring the benefits (or not) of corporate working (Hoskins 2009) and comparisons of health visiting and nursing education with examples gathered where registered nurses have been employed in place of health visitors to illustrate the differences in skills and knowledge between the two professional groups (Newland 2009).

2.3.2 Proposals for a single Community Health Nurse (CHN) role

In 2006, the policy directive ‘Visible, Accessible and Integrated Care’ went further through proposing the creation of a new community nursing discipline. It proposed a single Community Health Nurse (CHN) role in place of the three distinct specialities of district nursing, school nursing and health visiting. These proposals reflected wider shifts, outlined in ‘Delivering for Health’, from a hospital-based to a community-based health service (Scottish Executive 2005b). The model was initially piloted in the NHS Board areas of Highland, Tayside, the Borders and Lothian. In 2008, community nursing in Lothian changed from their original pilot of the CHN model towards a focus on a team approach to service delivery. They remained a pilot site at this stage, however, were not included in the later evaluation of the work. Reporting on these developments suggests a high level of professional resistance to changes being imposed on their practice with the boundaries between health visiting and district nursing being reinforced by those within the health care profession. This resistance is illustrated in the analysis by the community nursing profession in Lothian after their withdrawal from their initial plans for the CHN programme which focused on ‘lessons learnt’ from the responses of the community nursing practitioners. Their responses focused on their resistance to the programme of which this example, which focused on professional boundaries, is typical:

There remained stereotypes between the disciplines with recurrent concerns about HVs [Health Visitors] ‘doing’ leg ulcers and DNs [District Nurses] ‘doing’ child protection, enforcing ‘them and us’ attitudes (Lothian NHS Board, 2008:6).

The CHN and the piloting of the model saw evidence of resistance from within the community nursing workforce across Scotland. This was documented by the Queen’s Nursing Institute Scotland (QNIS) and in research commissioned by the Scottish Government to, ‘provide insight into the structural and other issues which affected the uptake and implementation of the new role’ (Elliott, Kennedy et al. 2012:1). Reports by the QNIS provide a strong sense of the concerns of the community health nurse workforce in terms of the loss of their unique professional identity formed through the development of specialist skills and knowledge with subgroups of the population (e.g. for health visitors this is children and families). The report by Elliot et al. (2012:8) commissioned by the Scottish Government provides a more anodyne account of the problems encountered in the pilot

which they pin down to the three interrelated areas of, 'the strategic vision of the new role, ownership of the new role, and critical mass'. The research by Elliott and colleagues changed direction after initial fieldwork indicated that there was widespread 'inertia' around the model with it either not being implemented or any implementation having already become immeasurable as the model dissipated. This led to one of their research aims to shift from, 'evaluate the impact of the new model of practice on both staff and patients (including carers)' to, 'provide insight into the structural and other issues which affect the uptake and implementation of the Community Health Nurse role' (Elliott, Kennedy et al. 2012:6). A paper based on studies of the CHN role exploring professional boundary work, including an exploration of the use of the term 'jack of all trades, master of none' used by community nurses to undermine the CHN role, has recently been published (Gray, Hogg et al. 2011). This is one means through which the resistance of community nurses locally has begun to be extrapolated to wider communities of practice.

The resistance of the health visitors of the community nursing workforce to the CHN model was a response heavily influenced by other developments in the early years such as Hall 4, the early years framework and GIRFEC (Pollock 2009). Community nurses reviewing the proposed changes in relation to the impacts they had felt to their practice attributed these felt impacts to changes brought about by these respective policy developments. Pollock (2009) illustrates this by drawing on the words of two of the focus group respondents who took part in the study by the QNIS:

Hall 4 gave us the opportunity to deliver intensive interventions to vulnerable families but the core service is lost. Children have not had the development checks, and if the CHN is in place we will only have a superficial relationship with families (Pollock 2009:8).

We service the public and need to keep them at the centre – keep the patients there, not at the outside, as shown in the model. The CHN model does not help with joint working. GIRFEC does (Pollock 2009:8).

A message from the respondents, which Pollock (2009:11) uses in her conclusion, is that, 'attendees felt that the CHN model "was getting it wrong for every child"'. This draws on and illustrates an internalisation of the policy discourses of Getting it Right for Every Child.

The response, in the form of resistance, to changes to the health visiting profession has also been shaped by other professional groups. General Practitioners (GPs) in Glasgow have been active in lobbying the Scottish Parliament in relation to changes to the health visiting service. A petition by the Local Medical Council (LMC) in NHS Greater Glasgow and Clyde, taken by a delegation of GPs to the Scottish Government, asked for, ‘a halt to the review, transparent consultation and a jointly created new and improved review involving the opinions of all stakeholders – the most important of these stakeholders, being our patients’ (Mackintosh 2008). In conjunction, in a letter to the Finance Committee of the Scottish Parliament, Glasgow GPs marked out the lack of vision in health visiting policy they believed there had been over the last 10 years and argued for funding for the health visiting profession, in particular, to increase numbers and develop training (Mackintosh 2011).

2.3.3 Context: Community nursing in Scotland in the aftermath of the CHN pilot

In the aftermath of the CHN pilot, and the model being disbanded, the Modernising Board for Nursing in the Community (MNiC) was established in 2009 with the aim:

... to support NHS Scotland to provide high quality, sustainable nursing care in the community by assisting NHS Boards to modernise and further develop community nursing services which meet the challenges of providing community care which is fit for the 21st Century and delivers clear benefits for patients (Scottish Government 2009).

It is the intention of the Modernising Board to develop a framework which makes clear where the role of existing community nursing professions is of best value while at the same time facilitating the development of new roles to provide additional adaptability and flexibility’ (Statement of Intent: Modernising Nursing in the Community Board) (Scottish Government 2012f).

Three sub-groups were established by the Modernising Nursing in the Community Board, one of which focuses on children, young people and families. Evidence around the early years and vulnerability and its impact throughout the lifecourse was used to legitimise this decision. In this way, the forging of a moral imperative between the early years and the professional work of public health nurses, including health visitors, becomes evident:

The decision by the Modernising Nursing in the Community Programme Board (MNiC) to focus on the development of a Framework for Public Health Nursing

teams (Health Visiting, School Nursing), in the first instance, was informed by growing evidence about the extent to which both vulnerabilities and potentials in adult life are shaped by experiences pre-birth and in our early years (Scottish Government, 2012e).

The MNiC has focused its efforts on generating an evidence-base, developing universal pathways of care, and developing a framework for public health nursing careers. A 'Pathway of Care for Vulnerable Families (0-3)' (Scottish Government 2011c), which emerged out of the pathway for universal services, clearly located and categorised vulnerability in relation to sub-groups who have been constituted through dominant risk discourses, for example, those using drugs or alcohol (or both), refugees, asylum seekers and so on, albeit as examples only. This work is contextualised in relation to a Quality agenda which, although related in the text to work with children and families in the community, has a clear clinical orientation around clinicians, patients, cleanliness, and clinical excellence (Scottish Government 2010d).

Whereas in Scotland there are no specific proposals for increasing the health visiting workforce, in England, the Health Visitor Implementation Plan (HVIP) sets out how the health visiting workforce will be expanded by 4,200 health visitors over the next 4 years. In real terms, it has been suggested, this means that 6,000 health visitors will be needed to take account for those who will leave the workforce through retirement or other reasons (Calkin 2011). In England, a review of the health visitor role has been documented in the review, 'Facing the Future'. This review has been the focus of work by academics who have analysed it using discourse analysis and through drawing on the Foucauldian concepts of discourse, knowledge and power (Greenway, Dieppe et al. 2008). Their work provides an alternative view to the consultative culture evident in policy making. These consultative processes tend to give the suggestion that the views of those consulted will be considered and valued in the policy-making process which is evidenced in the keenness of policy-makers to highlight the number of people and processes involved in consultations (e.g. Garvie's Hall 4 refresh presentation, 2011). Greenway and colleagues (2008:29) suggest, however, that, 'although "Facing the Future" purports to reflect a consultative review and to encourage debate within the health visiting profession, its form is more akin to a promotional document to implement government proposals for social change'. They

highlight how the document works to shift the emphasis of health visiting practice from relationship building to achieving outcomes through a service provided by teams of community health nurses and assistants and how the focus, despite a wide body of knowledge now generated around social determinants of health, is on individual lifestyle change which, they argue, is in line with, 'contemporary public health discourse' (Greenway, Dieppe et al. 2008:29). While the HVIP suggests that there is political will to increase the number of health visitors in the workforce, doubt has been cast over whether this is achievable given the limited current progress towards the aim (Calkin 2011).

There is a narrative developing around the demise and/or survival of the health visiting profession which saw a peak in the period of the CHN model pilot in Scotland. This discussion has continued since the pilot's abandonment and has been contributed to by a range of groups. The publication of a report by the RCN where they stated their position on health visiting and its future is one example of a contribution to this debate (Royal College of Nursing 2011). In conjunction, a push for evidence of effectiveness has been taken up within the health visiting profession's academic community as demonstrated in a recently published CPHVA/Unite the Union report which provides evidence that the health visiting profession is committed and working to ensure their survival (CPHVA and Unite the Union 2009).

In the last decade, while the community nursing profession has been experiencing, and responding to, a plethora of policy changes aimed at its practices, it has seen legislative changes where it was removed from the UKCC register as a separate discipline and merged with nursing and changes to their pay and conditions through Agenda for Change (Hoskins 2009; Cowley 2010). These policy changes led to the banding of health visitors which many did not feel reflected their professional experience and responsibilities as this anonymous response to a post on Nursing Times.net in response to the launch of the HVIP for England suggests:

As a qualified Health Visitor I believe that a large number of Health Visitors (based upon remarks past and discussions held amongst ourselves) would leave Health Visiting at the earliest opportunity due to the fact that we now do not perform the role in public health and regarding support that we once did. We are being used as cheap management of teams whereby although, only paid as a 6, we run skill mix

teams. If you discussed with Health Visitors whether they would rather be “hands on” most would respond that the reason that they trained for this profession was to be hands on. An example of this is regarding the Edinburgh Postnatal Depression Scoring – why would I delegate this task to another person, when I undertook [sic] the original assessment! Unless I can see through my RGN’s eyes, how would I know the subtle changes in the condition of the living accommodation or any decline in mood. But, we are now asked to delegate this task and be ACCOUNTABLE for any deficit in care that may result in depression being missed! (Anonymous, 18 Feb 2011 5:30 pm) (Reader response to article by Calkin 2011).

This account also reflects the tensions around technologies of assessment where the effectiveness of the tools used can only be understood within the wider contexts of the role of professional knowledge and the practice of good judgement in their use. This theme is developed in the findings of this thesis and reported in Chapter 6. Although published responses from community nurses express the widespread resistance within the community to changes to their practices, this response, without editing or analysis, works to capture the emotional strain also expressed by the profession through consultation and research processes (Pollock 2009; Elliott, Kennedy et al. 2012).

2.4 Discussion

Hall 4 is a UK-wide policy and how health visiting develops in one nation affects the others through sharing of policy, practice and academic ideas through published papers and other communications. This said, Hall 4 has developed in a particular context of Scottish devolution, where the process of its implementation can be better understood through reference to other policies on the early years and community nursing.

While the early years has become a focus of policy I would tentatively suggest that there are crucial areas where policies on the early years disconnect, for example, between universalism and targeted approaches, and focusing on individuals rather than structural change, making the achievement of implicit and explicit health inequalities goals unlikely. At the same time, the intractability of vulnerability is evident where policy tries to dissipate the experience of vulnerability in many different ways but there is always resistance and new forms emerging.

There is evidence in policy of an emphasis on enabling agencies to work together. This does little, however, to consider the boundaries of professional groups and organisations which are hidden in the discourse of inter-agency working around, for example, GIRFEC. Inter-agency working is often simplified and presented as a matter of organisation and communication, and presented as unproblematic in policy. Evaluations of interventions such as Starting Well, however, tend to suggest that attention to professional relationships and boundaries is required.

Hall 4 was, in part, a response to the diminishing number of health visitors:

... when resources are limited and skilled professionals are in short supply, it is unquestionably important to minimise routine tasks, whose benefits are uncertain, in order to release time and energy for children with higher levels of need (Hall and Elliman 2006:345).

Since then, there has been evidence of resistance from within the community nursing professions to changes to their work practices with the high profile ‘ditching’ of the community nursing review and single role. In response to this, the health visiting profession is now being constructed within policy as workable as it is, but, in need of a greater focus on evidence-base and the careers of public health nurses. There has been a shifting narrative around the health visiting profession and its own future in the last decade and since Hall 4 was published. The focus on risk and early intervention in early years policies has been a constant, and increasingly embedded⁷, presence throughout this time.

On this basis, conceptualisations of universality and targeting show a strong and ambivalent presence in policy. Hall 4 recommends that, ‘there should be a universal or core programme available to all ... plus additional services targeted to those who need them’ (Hall and Elliman 2006:337). Preceding policy on community nursing in Scotland, for example, ‘Nursing for Health’ also suggested a move towards a more targeted service (Scottish Executive 2001). In line with this policy, targeted interventions, such as Starting Well and the FNP, have been a main focus of policy. In GIRFEC, and in the Early Years Framework,

⁷ This refers to inter-textuality where concepts become embedded through the relationships between the text of different policy documents as well as being present in any one individual policy (Fox, 1999).

universality and targeting sit uneasily alongside one another. This conflict suggests a continuing tension around practice and policy. These tensions in policy, which are fundamental to how services for children and their families are provided and experienced, require recourse through academic⁸ thought on governance and welfare.

Key conceptual issues shaping the early years agenda around risk, evidence-base and health visiting practice will continue as themes throughout this thesis.

⁸ I use the word academic as a collective term for intellectual inquiry rather than in reference to academics as a group of people.

3.0 Introduction

This review reflects the diversity of literature relevant to a study of the implementation of Hall 4. The literature draws on sociology, philosophy, childhood studies, nursing studies, medicine, social and political sciences, and includes disciplines which are either aligned to or part of these, such as paediatrics, health visiting, midwifery, general practice, public health and social work. This vast diversity demanded a wide yet in-depth search strategy and an intuitive and reflexive analysis of the literature to conceptualise Hall 4 in relation to contemporary thought around health visiting and mothering practices and to develop a research methodology which could respond to that analysis.

The relationship between power and knowledge are developed through a critique of how the construct of the evidence-base has become a central and defining characteristic of the knowledge base and practices of the health professions. Theoretically, I locate these debates in relation to medicine, normality and risk. Through a wider literature which is of relevance to Hall, predominantly from the disciplines of health visiting and social work, I set the context of the study: first, by exploring historical and contemporary issues in health visiting where I consider how literature both reinforces and challenges social trends shaping health visiting practice; second, through consideration of parenting⁹, in particular the influence of gender; and, third, by exploring the interplay between lay and professional knowledge around parenting and childcare. In the final section of the review, I focus on risk, vulnerability and child protection. To do this I focus on theory on the concept of risk which is underdeveloped in the health visiting literature, but present in the social work literature. I conclude this review with a consideration of how, and the extent to which, these conceptualisations of risk have been taken up in the health visiting literature.

⁹ The focus in this study is on mothering rather than parenting. The methodological issues around recruiting mothers over fathers to the study are discussed in Chapter 4. The theoretical debates on the use of the gender-neutral term 'parenting' in policy and how it belies the gendered nature for caring in families is discussed in sections 3.4.3 and 3.4.5.

3.1 The process of scoping the literature

My aim in collating and reviewing the literature has been to explore the key concepts, sources and types of evidence pertaining to the topic of Hall (Arksey and O'Malley 2005). Literature searches were carried out throughout the course of the study between 2006 and 2012. A number of literature databases were searched, including CINHALL, MEDLINE, ASSIA, International Bibliography of the Social Sciences, ERIC, PubMed Central and the University of Edinburgh Searcher (which searches across databases). Key words and combinations of key words included formulations of: health visitor, parenting, Health for All Children, vulnerability, child health, child well-being, social work, risk, screening, child protection and health policy. In conjunction, key journals were searched, including the Journal of Advanced Nursing, Community Practitioner, Sociology of Health and Illness, Social Science and Medicine, the British Medical Journal and the British Journal of General Practice. References highlighted in the scoping discussions and which were identified through reference lists were also followed up.

The majority of the literature in this review is British, and hence, contextualised within the British health service. This is also the context within which Hall 4, and Hall more broadly, has been developed and implemented. The predominance of studies of health visiting reflects the widely accepted position of health visitors as the primary health professional group involved in the implementation of Hall. Where literature originates from a different region/continent or country, for example, the United States, Norway, Ireland, Australia and New Zealand, this has often been published in comparison to the UK system because there are distinct differences or similarities between health visiting and the system in place in these countries. Where this is the case, I use the language which the authors do themselves, for example, public health nurse (Norway), public health nurse (Ireland), child and family health nurse (Australia) and Plunket nurse (New Zealand), in order to maintain the health service context of the country where the research was carried out.

3.2 Hall as a research topic

3.2.1 Evidence-base and Hall

Hall 4 as a policy, discussed in Chapter 2, published in the four Hall reports, has been accompanied by articles in peer review journals over the last three decades, a trend which is continuing within current publications in 2011 and 2012 (e.g. Machin, Machin et al. 2011; e.g. Condon 2011a). These articles have been published in journals broadly associated with a range of health professions, including paediatrics, general practice, nursing and health visiting, and include the British Medical Journal, Journal of Advanced Nursing, British Journal of General Practice, Journal of Public Medicine, Archives for Disease of the Child, Child: care, health and development, and Community Practitioner and reflect the range of professional groups upon whose practices Hall has touched.

In an early paper published by paediatrician Professor David Hall (one of the architects of Health for All Children) and his colleagues, there is an emphasis on influencing the practices of other professional groups through the sharing of their expert knowledge (Baird and Hall 1985). Hall is contextualised through the need for an evidence-base and professional consensus to inform practice relating to child health surveillance (predominantly screening). Two decades later, in a paper published again by Professor Hall and a paediatrician colleague, there is an ideological shift evident towards a need for increased health promotion supported through a concurrent change of name from the child health surveillance programme to the child health promotion programme (Blair and Hall 2006). There is also a shift in how the evidence-base which informs practice, and upon which practice is based, is and should be generated. Whereas clinical experience was the focus of moves to generate an evidence-base for practice in the paper published in 1985, it is empirical research categorised as ‘developmental’ and ‘interventional’ research which is the focus in the paper published in 2006 (Baird and Hall 1985; Blair and Hall 2006). Whereas the expertise upon which Hall is based remains heavily influenced by medicine, the scope for intervention broadens its base to a range of professions, including health visiting, social work, and other early years professionals. The shift towards empirical research as the primary unit of evidence also reflects a wider and often contested trend within the health professions

towards evidence-based practice (King and Appleton 1997; Kelsey and Robinson 1999; Rycroft-Malone, Seers et al. 2004), with the research reviewed privileging some international research studies (and the methods used), for example, North American interventional studies of home visiting programmes such as Headstart (Blair and Hall 2006), over research generated within the cultural and social contexts shaping the health of the population in the United Kingdom. A parallel literature based on empirical research focusing on specific aspects of the recommendations of Hall, often published in collaboration with other health professionals, including health visitors (Bowns, Crofts et al. 2000; Crofts, Bowns et al. 2000), indicates a political imperative to include health visitors as researchers as well as the researched. The work and practices of the health visiting profession in the context of the previous or subsequent recommendations of Hall is often the focus of this research (Bowns, Crofts et al. 2000; Crofts, Bowns et al. 2000).

A focus on ‘targeting’ to need, absent in the literature of the 1980s, becomes evident in this literature where routine child health surveillance is viewed to be a ‘constraint on targeting’ (Crofts, Bowns et al. 2000:295). Through an analysis of data collected routinely to look at how the size of health visiting caseloads and the number of contacts which health visitors had with families correlated with deprivation factors and perceived levels of need, Crofts and colleagues (2000:95) suggest that a ‘more equitable allocation of health visitors and more explicit targeting policies might increase the effectiveness of the health visiting service’. In a second study by the same team of researchers, a postal questionnaire was sent to a sample of 403 mothers assessed to be ‘low priority’ by their health visitors (Bowns, Crofts et al. 2000). This sets as its context increased targeting on ‘high-risk groups’ and takes as its starting point that ‘low-risk’ mothers are largely satisfied with the service they receive. Hence, they suggest, it has been assumed that they would ‘tolerate some further reduction in their contact with their health visitors’ (Bowns, Crofts et al. 2000:806-807). They conclude that most mothers are satisfied with the service with dissatisfaction often being in relation to timing and convenience concerns about clinics and home visits and the advice they received. Satisfaction studies, however, neglect the desire of new mothers to be understood as coping. In conjunction, they take little note of the potential disciplinary nature of health visiting practice, where mothers can experience their relationships with

health visitors as supportive and of surveillance at one and the same time, which can lead to under reporting of difficulties in both research and health visiting practice itself (Wilson 2001; Peckover 2002a).

The call for an evidence-base to inform child health surveillance practices has been paralleled with a research literature on Hall in peer-reviewed journals. The Hall reports have brought child health surveillance into the realm of public policy with Hall itself, in turn, being scrutinised. Butler (1997a; Butler 1997b), through a postal survey of health visitors, community medical officers, paediatricians, GPs and managers, explores the changes in child health surveillance in the context of Hall, the 1990 GP contract, the National Health Service and Community Care Act 1990 and changes to the work of community doctors and health visitors. The research aims and its findings placed the work practices of different professional groups in the context of wider structural and economic constraints and the internal markets introduced in the NHS in the 1990s. Responses were compiled from the different professional groups, for example, health visitors, community doctors, GPs, and paediatricians, about their relationships with one another, the impact of structural factors related to NHS organisation on their work practice, and the difficulties they experience in having their expertise recognised and measured reflect wider trends, each of which have been of long interest to medical sociologists and a range of other academic disciplines, around health, evidence (and increasingly, evidence-base) and expertise.

Through the 1990s, literature was published where the effectiveness of child health surveillance with a focus on screening for developmental difficulties was contested by paediatricians (Dearlove and Kearney 1990) and those working in General Practice (Hampshire, Blair et al. 1999), with the effectiveness of parents in identifying developmental difficulties being studied through the use of randomisation between parent-initiated difficulties and those identified through the standard child health surveillance programme (Dearlove and Illingworth 1999). This growing body of dissent from within the medical professions around the effectiveness of screening tests embodied in the child health surveillance programme, particularly for those within the population deemed to be most 'vulnerable', is part of the documentation of a developing knowledge base and swathe of

professional opinion, which would act to influence a shift from child health surveillance to child health promotion reflected in both the name and emphasis of the programme outlined in the fourth Hall report (Blair and Hall 2006). The evidence-base for child health promotion is constructed as present in part (e.g. through North American studies), but also as problematic, due to the complexity of the interventions (Hall and Elliman 2006). At the same time, a narrative, which has developed further since, is present in the literature on the need for effective intervention necessitating political expediency due to the extent and depth of evidence about the neurological development of children (Blair and Hall 2006). The force of this narrative has prompted questions to be raised of the claims made of neuroscience in relation to the early years for fear of the impact it may have on already marginalised groups (Wilson 2002).

The work by David Olds has been particularly influential in determining the nature of interventions around the early years. His work is drawn on in Hall 4 (Hall and Elliman 2006) and in published papers exploring the existing evidence in relation to the early years (Blair and Hall 2006). The Family Nurse Partnership (FNP) in both Scotland and England is based on the model of early years intervention developed by Olds. Olds has published work on the Nurse-Family Partnership, which is the name of the non-profit organisation based in the United States. His body of work spans over three decades since 1977. Its focus is on first-time parents, in their homes, with nurses providing the programme and begins during pregnancy.

Developing an evidence-base on and through the work has been a central and defining aspect of the work. Olds has used randomised controlled trials (RCTs) to examine a range of aspects of the programme (Olds, Henderson et al. 1995; Olds, Robinson et al. 2002). A full RCT based on the programme is also a condition of the FNP licence. The attraction of an intervention which has been systematically evaluated over decades and which has an evidence-base where it has been shown to produce effects on maternal and child outcomes is palpable within policy and practice communities in Scotland. At the same time, while it provides an evidence-base on the maternal and child outcomes for the parents taking part in

the intervention, questions remain as to whether it can produce benefits for (or potentially be to the detriment of) all families with young children.

With the publication of the fourth Hall report and the concurrent academic literature, there is a widening of the professional net of expertise where teams of professionals from different disciplines and health promotion are proffered as the way forward to meet the needs of vulnerable groups. The focus on health promotion is argued to offer the health visiting profession opportunities to excel in an area of their own expertise (Cowley and Billings 1999). This view is reinforced through a study by Hampshire and colleagues (2001) using semi-structured interviews with a health visitor and GP from 28 general practices and an analysis of the content of 2001 child health surveillance reviews, suggesting that, when asked, health visitors took it upon themselves to allocate health promotion as their responsibility. They found that both the health visitors and GPs felt it was the role of the health visitor to discuss health promotion at child health surveillance reviews. The topic of health promotion in the research takes up an individualistic notion of health promotion where it explores health visitors' and GPs' approaches to talking to and educating parents about specific topics, for example, injury prevention and healthy eating, in relation to their pre-school children (Hampshire, Blair et al. 2001).

Health visitors are identified by paediatricians, in the early literature around Hall, as the people who are charged with the implementation of Hall and are central to its success (Baird and Hall 1985). They are strangely absent, however, in the later literature with no specific mention of them in Blair and Hall's (2006) paper in favour of promoting the need for 'multi-disciplinary' working and situating the work of paediatricians within this context. The research published in the aftermath of Hall 4 reflects the extent to which this role as policy implementors has been internalised by the profession where, despite wide variations in practice, health visitors have accepted that child health surveillance/promotion, as encapsulated within Hall 4, is primarily about their practice. With this a given, their approach has been to respond to, and at times resist, the recommendations provided. Condon (2008, 2011a) explored the extent to which the recommendations of Hall 4 are reflected in health visitors' practice. She used a postal questionnaire based survey with a

sample of 1,537 health visitors in 2005 and what she refers to as a ‘nested’ qualitative in-depth telephone interview study with 25 health visitors. Her analysis provides layers of insight into how Hall 4 has shaped health visiting and influenced health visitors’ existing practices. Machin and colleagues (2011), through a grounded theory study where they used qualitative methods to interview 17 health visitors, explore how health visitors perceived the changes in their professional practice. These two studies both focus on health visitors’ own experiences and perceptions of implementing Hall 4 and the impact which it has had on their practice over consideration of the ‘truth’ of the content of the Hall 4 recommendations (Foucault 1980:132) which has been heavily influenced by knowledge generated outside of their profession.

Charged, however, by themselves and others, with the implementation of Hall, health visitors have positioned themselves politically in their responses. There is evidence in articles which have been published, mainly in their own professional journal, *Community Practitioner*, that they are expecting changes to their practice. They respond with encouragement to their profession to carry on despite the challenges they themselves (Cowley 2010) as well as observers have purported it to be facing (Brocklehurst 2004). Articles which work to capture the ‘mood’ of the profession are evident in the literature, such as ‘Nothing to fear from Hall’ (Twinn 1990), published a year after the first Hall report, followed by a number of articles focusing on health visitors’ responses to policy and practice changes from Hall as well as other governmental reviews of health visiting practice (Thurtle 2005; Condon 2011b; Brigham, Maxwell et al. 2012).

3.2.2 Health visiting, evidence-base and the effectiveness agenda

Over the lifespan of Hall an exponential growth is observable in the literature published in academic and professional journals affiliated with the health professions both urging and challenging the need for evidence-base to inform policy and practice. There are a multiplicity of terms used, including ‘evidence-informed policy’ (Bunn and Kendall 2011), ‘evidence-based practice’ (Rycroft-Malone, Seers et al. 2004), ‘evidence-based medicine’ (Goldenberg 2006), ‘research-based medicine’ (King and Appleton 1997), ‘evidence-based care’ (Welsh 2001) and ‘knowledge-based health services’ (Kelsey and Robinson 1999).

The multiple terms¹⁰ in use reflect an ambiguous relationship between health policy, practice and research.

The literature suggests that the relationship between evidence-base and professional practice is characteristically ambiguous, with the pathways between evidence-base and practice imbued with professional politics. The extent and complexity of this relationship is crystallised in an article by Kelsey and Robinson (1999), lecturers in community nursing and public health, in the *British Journal of General Practice*, and further responded to in a letter to the journal by Bhrolchain (1999), a paediatrician, three months later. Kelsey and Robinson (1999:5) argue that an evidence-base which focuses on systematic reviews and which challenges aspects of the screening for developmental and sensory problems which were carried out by health visitors did little to recognise health visitors' role in child protection through a focus on the 'whole' child over screening for specific problems. The contested nature of evidence is visible in Bhrolchain's response who suggests, by drawing on RCTs from North America and the HTA report on hearing screening and forthcoming systematic reviews of home visiting in the UK, that 'many health visiting interventions are already evidence-based' (Bhrolchain 1999:313), and, in doing so, argues that an evidence-base proving the effectiveness of many of the practices of the health visiting profession already exists. The construct of evidence-based practice is being used, in different ways, by both authors as a tool with which to argue against one another, but, for their common concern that the existing health visiting service is not reduced.

Health visitors are identified in the literature as the key professional group in contact with babies, young children and their parents in their homes and other settings and as influential in the successful implementation of Hall (Bowns, Crofts et al. 2000; Crofts, Bowns et al. 2000). This positioning presents a conundrum where there is a quest for a sound evidence-base to inform Hall 4, which, itself, is dependent on the evidence-base of health visiting work being legitimised. The existing evidence-base of health visiting, however, is often viewed as lacking (Bunn and Kendall 2011). At the same time, to strengthen the evidence-

¹⁰ I use the term evidence-base throughout this thesis for consistency and clarity. I do so to explore rather than compound its use.

base is seen as problematic due to the nature of the work (Elkan, Blair et al. 2000). This scenario has played out in practice, with its presence seen in the literature, in three ways: first, the introduction of targeted interventions to sub-groups of the population in a bid to evaluate them (Starting Well) or because they have been evaluated (FNP), albeit, for the latter, not within the health contexts of the United Kingdom. The contributions to the evidence-based debates on the effective interventions in the early years goes some way to illustrate the complexities which surround thinking about evidence-base and its influence on policy and practice. The possibilities for the use of the evidence from the evaluations of some interventions, it has been suggested, have been limited by the methods used (Geddes, Haw et al. 2010). In conjunction, studies which have been carried out have pointed towards there being complex and unintended consequences from some interventions. Evaluations of Sure Start, for example, revealed that it was not reaching very deprived groups (Belsky, Melhuish et al. 2006), and research based on the Starting Well programme illustrated how early targeting cannot guarantee that all vulnerable families are being reached (Wright, Jeffrey et al. 2009). A second aspect has been a loosening of the evidence-base belt in the Hall 4 report. While an evidence-based approach is used to support the need for intervention in the early years (Blair and Hall 2006), an hierarchical view of evidence-base underpins the view taken by Hall and colleagues who suggest that it is important ‘to adopt an evidence-based approach wherever possible’, and, at the same time, go on to suggest that ‘it will never be possible to make recommendations which are wholly based on scientific considerations. Studies on the impact of community-wider projects rarely follow traditional models of medical research and a pragmatic approach to interpretation and generalizability is needed’ (Hall and Elliman 2006:23). They urge readers that, in light of this ‘we must not be paralysed by uncertainty’ (Hall and Elliman 2006:23). Third, there have been moves to develop the evidence-base of health visiting practice (Elkan, Kendrick et al. 2000), with corresponding responses to the difficulties of achieving this (Elkan, Blair et al. 2000; Robinson 2000).

Moves to develop the evidence-base of health visiting practice have largely focused around a study by the NHS Research & Development Health Technology Assessment (HTA) Programme, one of a number of organisations which have both developed and sustained the

evidence-based movement. Efficiency and effectiveness are captured in the aim of the HTA Programme as the dominant motivations for evidence-based practice:

To ensure that high-quality research information on the costs, effectiveness and broader impact of health technologies is produced in the most efficient way for those who use, manage and work in the NHS. Research is undertaken in those areas where the evidence will lead to the greatest benefits to patients, either through improved patient outcomes or the most efficient use of NHS resources (Elkan, Kendrick et al. 2000:introduction page).

The brief of the HTA was ‘to review the literature concerning both the general effectiveness and the cost-effectiveness of home visiting by health visitors’ (Elkan, Kendrick et al. 2000:1). The name of the report (The effectiveness of domiciliary health visiting: a systematic review of international studies and selective review of the British literature) reflects the methodology used where ‘controlled studies’, mainly from North America, were reviewed in relation to cost effectiveness (Elkan, Kendrick et al. 2000:1). Studies which did not meet the criteria set for the study were reviewed and presented in a second part of the report along with the exploration of contemporary debates around health visiting.

In a commentary by Robinson (2000), reservations over such a review which focuses on ‘controlled studies’ (Elkan, Kendrick et al. 2000:1) are stated. The focus on controlled studies in the generation of an evidence-base of and for health visiting practice is constructed as complex and in danger of excluding what is known about health visiting as a social movement but at the same time, that the review has succeeded in overcoming difficulties (Robinson 2000:1315). Robinson (2000) reveals that it was the largest HTA review to date and the first to consider the work of an entire profession rather than a single issue, such as screening. The authors, in their defence of the processes they engaged in to generate an evidence-base, and in additional commentary about the process, adopt the position that resistance was futile. This stance reveals how members of the profession are both responding to the dominant scientific discourses shaping evidence-base and to how it has contributed to a growing discontent in the ‘midnight reckonings’ of the health visiting profession (Ceci 2003).

The impact of health visiting research on UK health policy, including Hall, was the topic of recent research by Bunn and Kendall (2011). In an analysis of more than 30 policy documents, analysis of the citations of 19 health visiting research papers and interviews with seven health visiting researchers their findings emulate much of the other literature on evidence-base where the studies which they refer to as ‘mainly qualitative, observational or reflexive’ are left without an analytical frame, and dismissed through constructing them in relation to research methods favoured in systematic reviews:

Many of the UK studies cited in policy documents were qualitative, observational and reflexive and a lack of evaluative research, in particular randomised controlled trials and other controlled evaluations, may limit the impact of health visiting research on health care policy in the UK (Bunn and Kendall 2011:169).

They suggest that these limitations have implications for the profession as they become excluded from the machinery of policy:

... the final stage in the information chain is the evaluation of interventions in controlled studies. Whilst RCTs are not necessarily appropriate for evaluating the health visiting profession as a whole, they may be suitable for evaluating components of the health visiting role ... (Bunn and Kendall 2011:186).

The limitations of the evidence-base of health visiting has been suggested to be multi-factorial, and partially, but substantively, located *within* the health visiting profession as lacking research capacity, theoretical base, status, role clarity and a diminishing workforce (Bunn and Kendall 2011:185). From this deficit model of health visiting capacity, the opening provided by generating an evidence-base which can prove effectiveness, has been argued to be an opportunity for the health visiting profession to produce a ‘striking impression’ (Elkan, Blair et al. 2000:1321). Robinson (2000), one of the authors of the HTA report, makes a call to her ‘profession’, its ‘research commissioners’ and ‘research educators’ to consider the research excluded from the HTA review where there were ‘major methodological limitations to many of the studies retrieved through the systematic search’ which ‘led to their subsequent exclusion through the study’s quality control procedures’ to enable them to improve their research capabilities (Robinson 2000:1315).

At the same time, Elkan, Blair and Robinson (2000) work to show that RCTs may never illuminate the effectiveness of home visiting by drawing on Halpern's (1984) evaluation framework which, they argue, was itself part of a response to the 'scientific' paradigm in North America. They construct home visiting as 'an elusive subject for "scientific" evaluation' by drawing on Halpern who suggests that:

... home-based early intervention is in some ways inherently non-standardised and idiosyncratic. In most programs, the home visitor enters into a young family's life, begins to assemble a portrait of strengths and stresses, attempts to respond to immediate parental concerns, and usually adapts whatever ... agenda he or she has to what is being learned about a family's needs. This flexibility and responsiveness, along with the long-term sustaining nature of support provided, constitute the unique strengths of home visiting program (Halpern 1984: 217; cited by Elkan, Blair et al. 2000).

It is argued that there is substantial 'anecdotal evidence' of the effectiveness of health visiting practices where the word 'anecdotal' acts powerfully to devalue its worth; as such, it is argued, more scientific evidence and methods are required to do the work of proving effectiveness (Elkan, Blair et al. 2000: 1321). 'Gut instincts' which have been argued to be a legitimate aspect of professional 'knowledge' (King and Appleton 1997) are not legitimised as an acceptable 'truth' in the discourse of evidence-base, so alternative approaches to evaluation, Elkan and colleagues (2000) suggest, are required:

Halpern believes that at present, the research evidence for the effectiveness of home visiting is lagging behind the reality of effective home visiting. Although there exists a plethora of anecdotal evidence that home-based early intervention is providing valuable support, at least to some families, limitations in research design have given rise to an underestimation of the effectiveness of home-based interventions (Elkan, Blair et al. 2000:1321).

The researchers suggest that as theory and research are interlinked, it will necessitate a more critical approach to the theory of health visiting practice to be developed before 'high-quality research' becomes possible (Elkan, Blair et al. 2000: 1322). Although the epistemological roots of evidence are being questioned, the philosophical position from which the requirement to prove effectiveness has become a given remains untouched.

A further response to the evidence-based movement is found in literature where the authors take up the challenge with the dominance of 'scientific' discourses in shaping how the evidence-base is formed, and the ways in which it is subsequently put to work in proving effectiveness and influencing practice. This challenge is similarly found in the health visitors' accounts and informs the analysis presented in Chapter 6 where the observational and relationship work of health visiting practice is found to be lacking due to its lack of responsiveness to the tools and paradigms through which evidence is formed and effectiveness judged. Elkan and colleagues (2000) do not question the philosophical premise of 'evidence-based practice' but work to provide an alternative viewpoint of what might constitute evidence. They do this by (re)constructing these alternative forms of knowledge as 'evidence'. King and Appleton (1997) reconstitute intuition as a valid knowledge about a situation which can inform practice through a review of literature through which they examine intuition's own evidence-base. Rycroft-Malone and colleagues (2004) argue that a stronger evidence-base for practice can be achieved through recognition and valuing diverse forms of evidence and suggest that there are four forms of knowledge which when brought together form a stronger evidence-base than knowledge from research evidence alone. The four forms they suggest are: research evidence; clinical experience; patients, clients and carers; and local context and environment. They conclude that 'fundamentally, drawing on these four sources of evidence will require the bringing together of two approaches to care: the external, scientific and the internal, intuitive.' (Rycroft-Malone, Seers et al. 2004:81). It has been argued that limiting subjectivity, objectivity, the scientific, rationality and reproducibility have been seen as defining characteristics of what evidence-base is (where other forms go unrecognised) (Kelsey and Robinson 1999), and where 'intuition as an element of judgement is often denigrated' (King and Appleton 1997:194). The authors of this literature on intuition work to reframe it in those very terms which have given other forms of evidence-base validity. Hence, intuition is brought back into the frame as knowledge which can be constituted as an evidence-base for practice. Schon (1983) suggests, however, that:

... there is a high, hard ground overlooking a swamp. On the high ground, manageable problems lend themselves to solution through the application of

researched-based theory and technique. In the swampy lowland, messy, confusing problems defy technical solution. (Cited by Welsh 2001).

The framing of intuition using existing and privileged technologies to generate its own evidence-base suggests attempts to legitimise solutions to complex social problems through the appropriation of technical machinery. The complexity of the social problems and the solutions, however, remain.

Put another way, evidence-base has become so embedded in practice where, as Goldenberg (2006: 2622) highlights, by drawing on the evidence-based medicine movement, that the use of evidence-base has become a moral playing card shaping the practices of health professionals:

The term “evidence-based medicine”, and its standard definition as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Sackett, Rosenberg, Gray, Haynes & Richardson, 1996: p. 71), has a ring of obviousness to it which makes it difficult to argue against. Few doctors, one suspects, would be willing to assert they do not attempt to base their clinical decision-making on available evidence.

Given this view, acceptance and manipulation using the technology has become, some of the literature suggests (e.g. Welsh, 2001), the only way to stimulate progress in professional practice, given the complexity of the social problems and the potential solutions.

At the same time, in the background, there is also a small body of literature where health visitors themselves, through knowledge of their practice, emphasise the importance of intuition in their practice, but work to undermine this by rejecting it or downplaying it as not scientific (Ling and Luker 2000).

3.3 Theoretical perspectives: Medicine, surveillance and normality

A critique of medicine has, for a long time, been a central concern in sociological writings, purported to have originated in the era of the European student revolutions in 1968 and Marxist responses to Parson’s structural functionalism which was criticised for being ‘overly politically conservative and supportive of medical authority’ (Lupton 1997:95). Since the 1980s, Foucault’s writings have been taken up by, and are reflected in, medical sociologists’

critiques of medicine (Lupton 1997:98). There are a number of aspects of Foucault's writings of relevance to a study of Hall 4. Although well known for his work on power, Foucault himself argued that his life project 'has been to create a history of the different modes by which, in our culture, human beings are made subjects' (Foucault 1982:777). Power, to Foucault, was not necessarily repressive, but could be a force for good. In this way, Lupton (1997:99) suggests that, 'the power that doctors have in relation to patients, therefore, might be thought of as a facilitating capacity or resource, a means of bringing into being the subjects of "doctor" and "patient" and the phenomenon of the patient's illness'. Thus, 'power is not a possession of particular social groups, but is relational, a strategy which is invested in and transmitted through all social groups' (Lupton 1997:99).

The influence of scientific medicine in the medicalisation of society, it has been argued, is profound, 'serving to monitor and administer the bodies of its citizens in an effort to regulate and maintain social order as well as promoting good health and productivity' (Lupton 1997:100). Health visitors have been identified as intermediaries of the state to influence the practices of the poor, which, along with environmental measures, aimed to improve the 'fitness of the nation' (Rose 2001:3). The focus on the mother and child becomes implicit in the literature where the 'disciplinary and tutelary measures' (Rose 2001:3) employed to achieve this aim focused on, 'the establishment and wide provision of antenatal care, birth notification, baby clinics, milk depots, infant welfare clinics, day nurseries, health visiting and nursery schools ensured that the early years of child development could be closely monitored' (Armstrong 1995:396). It was through increased monitoring of the child in the 20th century that surveillance of populations became established (Armstrong, 1995). Armstrong (1995), by making the link between the child and development, also draws us to towards the concept of normality as being relative to others in the population: 'The significance of the child was that it underwent growth and development: there was a constant threat that proper stages might not be negotiated that in its turn justified close medical observation' (Armstrong 1995:396). Armstrong (1995:397) uses familiar imagery relating to the monitoring of height and growth to show how the notion of normality came into being:

If there is one image that captures the nature of the machinery of observation that surrounded the child in those early decades of the twentieth century, it might well be the height and growth chart. Such charts contain a series of gently curving lines, each one representing the growth trajectory of a population of children. Each line marked the “normal” experience of a child ... A test of normal growth assumed the possibility of abnormal growth, yet how, from knowledge of other children’s growth, could the boundaries of normality be identified? ... In effect, the growth charts were significant for distributing the body of the child in a field delineated not by the absolute categories of physiology and pathology, but by the characteristics of the normal child. (Armstrong 1995:397)

Although ‘the nation’s health’ is still a political imperative, it is increasingly produced through economic and moral motivations (Rose 2001:5). Both Armstrong (1995) and Rose (2001) explore how the disciplinary machinery of surveillance has incorporated risk discourses, where, in Armstrong’s words (1995:403) the monitoring of ‘precarious normality delineates a new temporalised risk identity’ (Armstrong 1995:403). These are highly suggestive theorizations of health, surveillance, normality and risk which open a conceptual space through which to question the aims of child health surveillance which are being produced through the ‘evidence-based’ practices supported by Hall.

3.4 Context: Health visiting and parenting

3.4.1 Historical accounts of health visiting practice

Health visiting has been constructed through historical accounts as a profession of women who were mothers themselves engaged in influencing the mothering practices of other women. Accounts of the history of health visiting locate its origins in the 19th Century through the establishment of the Ladies’ National Association for the Diffusion of Sanitary Knowledge in 1857 and the Ladies’ Sanitary Reform Association, a branch of the Manchester and Salford Sanitary Reform Association, in 1861. It is constructed, from the outset, through assumptions about class and mothering practices. It is documented that ‘Bible Women’ were employed to educate the poor and that they were viewed to be in a good position to negotiate the difference between the upper and lower classes (Owen 1977). The concept of health visiting being a universal service is pinned in the literature to the legislative measure of the 1907 Notifications of Births Act through which health visitors gained access to information about every new birth.

3.4.2 Contemporary issues in health visiting practice

Themes around the role of health visitors and universality continue in the contemporary literature on health visiting. Health visiting practice is constructed in the literature by themselves and others as unsure, and lacking certainty over its goals, with the health visiting profession itself seen as lacking confidence in itself and its future. The 1980s and early 1990s saw the establishment of ‘models’ of health visiting (e.g. Billingham 1991; Twinn 1991) discussed in the literature, with discussion about the emphasis of health visiting practice in the late 1990s and early 2000s (Craig and Smith 1998; Cody 1999; Smith 2004), and debate over the role, contribution and future of health visiting through the 2000s up until the present year of 2012 (Kennedy, Christie et al. 2008; Appleton 2011; Peckover 2011; Brigham, Maxwell et al. 2012). At the heart of these debates are questions around health visiting roles (public health, psychological, support, surveillance, child protection, vulnerable families), who they should work with (across the life course or just families, and all families or just some families), whether health visiting is ‘effective’, and metaphorical ‘cries for help’ as (a few) health visiting and other observers suggest the profession may be slowly disappearing from sight.

The ‘role’ and ‘function’ of health visitors is a dominant thread in the contemporary health visiting literature. It is heavily problematised in the literature, with authors taking different approaches in their analysis of the ‘problem’, with terms such as ‘strengthening’ (Pritchard 2005) and ‘sharpening’ (Carr 2005) being used to describe the development required of the health visiting practice and its associated terms (in the 90s), such as health visitors feeling ‘pressured’ to shift roles from health promotion to a focus on clinical disorder (Cowley and Billings 1999).

A number of studies have made comparisons between systems of care for ‘well children’ (Kuo, Inkelas et al. 2006), highlighting an international interest in the subject. A comparative study by Kuo (2006) using literature and expert interviews showed differences between the structure of care and professional groups providing this care with the US being the only country to have the responsibility for well children care sit with a single provider

(Kuo, Inkelas et al. 2006). Differentiations have been made between approaches where a universal system was in place, for example, in Great Britain and Denmark and those where it has not been, for example, the United States (Kamerman and Kahn 1993). A comparative study by Ellefsen (2001) explores the similarities and differences between the Norwegian and Scottish health visiting systems. She interviewed 9 health visitors from Scotland and 12 from Norway. Her analysis revealed that both groups found that, although they experienced their profession as autonomous, there was an invisibility to their work where they found difficulties in evidencing it. While the Norwegian health visitors expressed greater involvement in managerial issues, the similarities between the two groups led Ellefsen (2001:318) to conclude that 'the core of health visiting extends beyond the limits of cultural and national boundaries' (Ellefsen 2001:318).

A persuasive literature through which health visitors themselves and others suggest that public health should be part of their role has been published over the last decade. It coincides with suggested name changes from health visiting with a number of other options being used in parallel with health visiting in the literature including specialist community public health nurse (Hoskins 2009:94), a term which has been rejected as part of concerns that a legislative move to remove health visiting from statute in 2001 and the closure of the health visiting register in 2004 has regulatory implications for the public and has hastened the potential demise of the profession (Cowley 2010). In a review of the health visiting response to pilot projects aimed at maximising health visitors roles in public health, health visitors are shown to be engaged in ideologies around public health, but lacking in necessary knowledge and skills:

Although health visitors and school nurses believed strongly they had a major public health role to play, they were found to lack knowledge and skills in areas fundamental to public health practice, including community development, partnership working, project management, team leadership, research and evaluation (Brocklehurst 2004:215).

The skills of public health practice have both a community and medical orientation in the literature (Brocklehurst 2004). This double-positioning sits at odds with the approach to public health which health visitors have adopted of accumulated community knowledge through working with individual families (Craig and Smith 1998). The relevance of this

contradiction becomes evident through understanding that medicine is also one of the professions through which health visiting's boundaries are shaped and its areas of autonomous practice defined (Dingwall 1977; Wilson 2003), and through which the health visiting profession defines itself through separation and resistance to any practice developments which they deem to be a form of 'medicalisation' (Cowley, Mitcheson et al. 2004).

An exploratory study by Smith (2004), where 27 health visitors from one NHS trust took part in focus groups, reveals that the adoption of a public health role by health visitors was one which health visitors themselves engaged with. His analysis of the health visitors' accounts of their public health role suggest that while resistance to changing practice were to an extent based in difficulties around leadership and their structural location within the NHS, they saw home visiting and their relationships with their clients as central to their child protection work, where Smith (2004) uses the term 'wrestle' which acts to emphasise the responsibility health visitors feel towards this aspect of their work:

They wrestled with the prospect of not being able to visit enough to build a relationship or losing contact with individual families where there may be child protection concerns (Smith 2004:22).

In this way, child protection is identified in the literature as the work of health visitors, which is their individual responsibility. At the same time, it is seen to be separate from public health work, rather than complemented by public health ideologies.

Public health nursing has been considered in terms of whether 'it threatens its [health visiting's] core functions' (Craig and Smith 1998) or is an optimistic development for the profession. Based on an analysis of the history of health visiting, Craig and Smith (1998) suggest scope for health visiting to take up a public health remit which adopts a social model of health, works from a population perspective and uses community development approaches. The fit of this in relation to individualised health and public health approaches 'dominated by epidemiology and the medical model of evidence-based practice', however, is questioned (Craig and Smith 1998:177). Hence, health visitors are seen as lacking in skills to fulfil a public health agenda, a public health agenda which is imposed and which

they are not taking on and/or are lacking skills in. An alternative perspective has been put forward recently by Peckover (2011) who suggests that it is through the coming together of health visiting's public health history, through which their identity as a profession has been formed, with the current 'safeguarding agenda' that the health visiting profession will be able to develop.

Most of the health visiting literature draws on observation or empirical research which, although displaying sound observations and analysis showing consistent (and at times divergent) themes (which recognise themselves as such), there is little theorisation in the work. A small body of work draws on the writings of Foucault in its analysis of the interplay between support and surveillance, and, by doing so, shows a complexity to health visiting practice (Bloor and McIntosh 1990; Wilson 2001; Peckover 2002a) not revealed in other studies. Peckover (2002a), using a qualitative approach where she interviewed 24 health visitors and 16 women who had experienced domestic violence and who were mothers, took a feminist poststructural approach to her analysis revealing the complexities inherent in health visiting practice. She questions the 'prevailing professional discourses' around the relationships between health visitors and their clients which emphasises empowerment and equality. Her theorisations lead her to conclude that by:

Understanding the policing role of health visiting, alongside their supportive role, draws attention to the exercise of power and the discourses that produce health visitors and mothers. This has implications for developing policy and practice, as it problematises the notion that health visitors' relationships with mothers are simple and straightforward (Peckover 2002a:375).

In a similar vein, Wilson (2001) adopts a qualitative approach in her small scale study where she interviewed five Plunket nurses (New Zealand child health nurses). She describes her analysis as using a 'Foucauldian approach to critical discourse analysis' (Wilson 2001:294). Her analysis again challenges the implied straightforwardness of the relationship between nurse and client and describes it rather as 'complex and precarious' (Wilson 2001:299). Bloor and McIntosh (1990) draw on data from two studies, one of health visiting and the other of therapeutic communities. In the health visiting study 80 mothers were interviewed, and in the study of therapeutic communities participant observation was used in four communities. By doing so they drew up a typology of client resistance with the aim of

showing that the ‘professional-client relationship is always a power relationship, and even in the process of professional-client contest the two parties are locked into a disciplinary relationship’ (Bloor and McIntosh 1990:180). Together these studies provide a different contribution within the literature which brings meaning to the complexity and chaos of health visiting practice and its uneasy relationship with evidence-base.

In conjunction, these studies use an iteration between theory and data analysis not evident in the majority of the empirical studies reported in the literature. All three studies draw on the work of Foucault through which his ideas begin to be incorporated into and form knowledge about health visiting practice. Each of the authors highlight their own processes of analysis by applying these theories where: Wilson (2001:295) has ‘drawn extensively, but selectively, on the ideas of Foucault’; Peckover (2011:372) informs us that while the ‘underpinning theoretical framework of feminist poststructuralism’ has informed her analysis she has also incorporated thinking from Silverman (1993) around the ‘situated and textual nature of the interview’; and Bloor and McIntosh (1990:160) state that they have adopted Foucault’s ideas about power and resistance and applied it in a *post hoc* analysis of data from two research settings to show how client resistance manifested in each. They also work to question the assumptions often made, and evident in much of the health visiting literature, which apply an uncritical stance to the professional-client relationship. Their analysis, problematising the health visiting/client relationship as it does, and reconstituting it as a disciplinary relationship, gives an opening which can be used to understand some of the other aspects talked about in the literature, for example, health visitors’ resistance to public health work which has been identified, most likely in part due to an unerring concern about child protection (Smith 2004); and how some aspects of their work remain hidden in the literature, for example, around child protection, despite widespread acknowledgement of its dominance in health visiting work in practice.

3.4.3 Gender, class and health visiting practice

An analysis of gender in relation to health visiting practice is approached from a number of diverse perspectives which in itself starts to illustrate the complexity of gendered relations. Edwards (1998), through her analysis of interviews with eighty-four community midwives,

health visitors, social workers and voluntary sector staff, in conjunction with ethnographic work, shows that although some men were not active in the care of their children, they are also ‘made absent’ through the practices of health and welfare professionals (Edwards 1998:260). Most health care workers, although they identified with the importance of dealing directly with both mothers and fathers involved in child care, did this to identify support for the mother and child and to facilitate their work and interactions with women, and not in terms of men as ‘co-parents’ (Edwards 1998:265). Pritchard (2005:236) used a qualitative methodology in a study with 35 health visitors, where she drew on feminist and educational work to show how, through her reading of feminist literature, she was led to recognise the importance of ‘new ways of looking at the health visitor and seeing “her” as a woman, as a mother, daughter, aunt, sister, partner, and developed a view that the empirical work needed to show the “whole person” doing the job not only the “professional woman”’. She considers the influencing nature of the metaphor ‘invisible’ in health visiting work and feminism and how ‘private knowledge’ gained from life events can transform relationships between health visitors and their clients (Pritchard 2005:240). This, along with other studies of health visiting practice, works to build a literature from within the health visiting profession that challenges the dominant scientific paradigm of an evidence-base. Peckover (2002b:256, 2003) in her study of health visitors’ practice in relation to domestic violence brought ‘analytical attention towards gendered power relations and discursive practices’. Her study of 24 health visitors revealed a ‘professional silence’ which Peckover (2003:206) suggests reflects patriarchal discourses around violence. Through focusing on health visitors’ accounts of their practices in relation specifically to men and children she shows how health visitors’ knowledge of domestic violence acted to increase their surveillance of mothers where they were also placed in the role of protectors of their children, and at the same time how the gendered practices of health visiting work acts to maintain discourses where the nature and extent of male violence is both minimised and silenced. A literature which analyses the gender in relation to health visiting practice therefore does exist, but is minimal, given the importance of gender in shaping the practices of the profession and the profession itself. In addition, the majority of studies reported in the literature are with female health visitors and mothers reflecting the dominance of women in the health visiting workforce and that the focus of their work with mothers and children. With the exception of

a few studies, gender relations are not analysed. Hence, the dominant patterns of relationships which are observable in health visiting practice are reflected in research findings but remain, most often, unanalysed.

Symonds (1991) in her comparative exploration of the meaning of health visiting and district nursing suggests that, in contrast to district nursing, which faced challenge over the physical nature of its work in a predominantly female occupation group, contradictions of class and gender were inherent in the construction of health visiting itself. She suggests that class division 'is constructed by the work practice itself and is not to be found in the class background of the practitioners' (Symonds 1991:262). Although class is discussed in the health visiting literature in relation to the historical origins of the profession as middle class women were recruited to influence the parenting practices of working class women (Owen 1977), Symonds' (1991) study is one of the few studies which addresses class to any notable extent, despite the existence of a well-developed sociological body of knowledge on this topic around class and mothering with potential relevance to health visiting practice (Duncan 2005; Lawler 2005).

3.4.4 Emotional and psychological support as health visiting practice

Alongside the calls for health visitors to take up their public health role, the health visitor's role in providing emotional and psychological support, as well as being constructed as an often forgotten aspect of health visiting work, sits with quiet reminders of its presence in the health visiting literature. Shepherd (2011), in her article 'Behind the scales: Child and family health nurses taking care of women's emotional wellbeing', draws on the symbolism of the scales and weighing of babies to reveal how child and family health nurses address the emotional needs of mothers through their work around ensuring the health and development of their baby. Similar to the methodology discussed by Bryans (2004), she employed multiple methods using observation of home visits and individual and group interviews in her bid, as a child and family health nurse herself, to 'understand what I took for granted, the implicit or hidden meanings behind the actions. Hence it was important to particularly take note of what appeared to be ordinary, routine, often unquestioned, aspects of nurses' practice' (Shepherd 2011:139). One of her main findings focuses around the

legitimacy of intuitive knowledge, where she describes how community health nurses found 'difficulty in articulating, even acknowledging, this instinctive knowing made them question the legitimacy of their own caring' (Shepherd 2011:141).

The health visitor's role in emotional and psychological support is medicalised and legitimised through identifying and supporting women with postnatal depression (Shepherd 2011:140) and their role is constructed as a 'holding relationship' where opportunities are sought to listen to the mothers and explore problems until other professionals are able to accept a referral for additional intervention (Cody 1999:119). Cody (1999), by reviewing existing literature, suggests that the psychological support role of health visiting has been neglected. Cody (1999) brings the health visiting relationship with her client(s) in their home centre stage to enable a phenomenological approach which allows health visitors to get 'into the families' experience of need' (Cody 1999:125). She suggests that home visiting and psychological support are role developments which the health visiting profession should prioritise. This is supported by literature which explores the framing of postnatal depression and its implications for the practices of the medical and health visiting professions (Lloyd and Hawe 2003:1792).

The health visiting literature of 2011 and 2012 suggests that there have been multiple responses to the increasing concern about the state of the health visiting profession. Osborn (2012) reports on a training programme for community nursery nurses and health visiting assistants to identify postnatal depression as health visitors become increasingly few in number and are stretched within their resources to work directly with children and families themselves (Osborn 2012). The increasing body of literature around this shift in practice suggests that postnatal depression, as well as being a medicalised condition in need of legitimate health visiting input, is bound by, and can be segmented from, the work of health visitors to become the work of others as part of a process of de-professionalisation (and resource savings). Wallbank (2012) reports on a programme of 'restorative clinical supervision' where 600 health visitors have taken part in a programme to explore 'the key issues with which health visiting teams are struggling, and provide effective solutions to reduce staff stress, encourage retention and increase job satisfaction' (Wallbank 2012:29).

The model, it is suggested, has ‘shown significant positive results in reducing the amount of stress and burnout professionals were experiencing and restoring their capacity to think and make decisions, potentially reducing risk within their organisations’ (Wallbank 2012:29). Wallbank (2012) reports on factors attributed to health visitor burnout including issues around leadership, communication, connectedness with their organisation, and workload pressures. A common strand throughout is the increase in risk discourse and increased focus on work with ‘complex children and families’ where team leaders ‘managing a complex caseload and operational responsibilities families will always take priority because of the potential risk attached’ and where health visitors’ increasing sense of themselves as providing an ‘emergency service’ leaves health visitors “‘knocking on the family’s door with a sponge”, hoping that they would not be at home as they were not feeling they would be able to manage their needs’ (Wallbank 2012:31). The concerns that authors are working to express in the recent literature can be traced back to the literature published in the 1990s. A questionnaire-based study by McDonald and colleagues (1997), where they sent three questionnaires to 24 NHS trusts, revealed anxieties across the community nursing professions with health visitors identifying concerns about being ‘marginalised’ in a move to primary care teams and a shift in focus from treating illness to health promotion. This study identifies a counter-intuitive concern, given health visitors’ long recognised expertise in health promotion, justified through how their ‘performance could be measured on the less quantifiable outcomes of preventable care’ (McDonald, Langford et al. 1997:263).

In conjunction with what constitutes health visiting work, a strong theme in the health visiting literature is whether services should be universal or targeted to sub-groups of the population. There are three aspects to this debate. First, an ideological one, over the aims of targeting (ever-reducing resources and increasing demand) and whether these (ever-reducing resources) can be better used to meet the needs of those deemed most in need of services. Second, and as an important consideration, of, if the ideology of targeting is accepted, which groups are targeted and how the individuals in these groups are identified. Third, and an often sidelined question, is whether targeting has implications for those outside as well as inside the identified groups, and hence, population-wide implications.

Elkan and colleagues (2001) (a number of whom were also part of the HTA review in 2000) use the work of epidemiologist Geoffrey Rose to argue for the retention of a universal health visiting service. They apply the examples of depression and child abuse to Rose's work to show how 'to target health visiting services only on those at high risk would be to leave untouched a vast burden of health and social problems', because, put simply, the number of people who are deemed as not especially 'high risk' far exceed those who are (Elkan, Robinson et al. 2001:113). The continuum of needs among a population means that in order to change the nature of a 'problem' it is necessary to recognise that 'the deviant tail of "trouble-makers" belongs to its parent distribution' (Rose 1993: 96, cited by Elkan, Robinson et al. 2001:116). To support only those who are experiencing, for example, severe depression, leaves untouched the majority of the population among whom many will also be experiencing some levels of depression, but who will form a sub-group of the population who are not considered 'needy' or 'high risk' (Elkan, Robinson et al. 2001).

The ease with which authors slip between the use of needs- and risk-based terms suggests an uncertainty around these concepts and an ambiguity about what the ideological basis for targeting is (needs (medical), rights (protection being a right which is also social in origin), risk, or vulnerability). The focus of the literature on some sub-groups of the population, for example, low-risk, vulnerable, or high risk, again acts to shape what is known about the impact of these different approaches. While research demands focus, the focus then acts to reinforce knowledge about certain sub-groups over others.

The literature suggests a fine balance between whether or not health visitor clients are understood in terms of consumerism, and hence consumers, or resource availability, and hence targeting/targets. Almond (2001) takes up the concept of consumerism in a bid to identify who the consumers of health visiting are and whether their voice has impacted on the provision of health visiting services. In attempting to assess the influence of consumers' views, Almond (2001:893) concludes that, 'consumerism has had relatively little impact on improving child health clinics although high levels of consumer satisfaction with the overall service exist'. Based on this finding, Almond (2001:899) surmises that, 'the reported high levels of mothers' satisfaction may explain why consumerism's influence in health visiting

is almost indeterminable. Changes are simply not deemed necessary.’ An alternative direction of travel, Almond (2001) suggests, is to bolster the evidence-base through the inclusion of parents who do not currently use health visiting services and to consider more active methods of consumer involvement than the passive modes, such as the surveys which are currently used. A qualitative study by Machen (1996), interviewing 23 first-time mothers, revealed a high level of satisfaction with the health visiting service among the mothers akin to the responses of a satisfaction survey where the findings, although suggestive and reported in relation to other research findings, lack consistent theorisation. A study by Knott and Latter (1999:582), who interviewed 12 mothers who they termed as ‘single, unsupported parents’, revealed that mothers felt that the emphasis of their interaction with health visitors was predominantly about the health and welfare of the child to the extent that the majority did not find their health visitors helpful which Knott and Latter (1999:582) suggest may have been because ‘their needs were not baby orientated and they did not perceive that the health visitor role could encompass other problems’ which is conceptualised loosely in the themes ‘They don’t weigh you’ and ‘It’s get in, get weighed and go’ (Knott and Latter 1999:584). In contrast, Bowns et al. (2000) in their satisfaction study of ‘low risk’ mothers, discussed previously, frame their argument in terms of targeting over consumerism.

Articles published by those in the health visiting profession, however, suggest a challenge to the notion of targeting (and dominance of scientific modes of evidence-base) which has led to the development of more complex methodologies to examine health visiting (Bryans and McIntosh 2000; Bryans 2004; Bryans 2005). Bryans (2004), based on her study where she used simulated health visitor visits to a client who was an actor, then conducted an interview after the simulated visit and observation of a real-life home visit with 15 health visitors, shows how these methods together could work to reveal the knowledge and expertise that health visitors used in their assessment of clients. She argues that there is a need to ‘develop sufficiently rigorous, systematic and accommodating approaches into this complex area’ and that findings based on such approaches could provide a platform for more effective needs-led targeting of health visiting services (Bryans 2004:624).

As well as methodologies for researching the assessment of health needs, the effectiveness of health needs assessment tools used in health visiting practice has been investigated through a body of work published by Cowley and colleagues (Cowley and Houston 2003; Cowley, Mitcheson et al. 2004; Appleton and Cowley 2008a; Appleton and Cowley 2008b). The studies report on in-depth case studies (Appleton and Cowley 2008a; Appleton and Cowley 2008b); a qualitative study of two different structured health needs assessment tools in two NHS Trust sites (Cowley, Mitcheson et al. 2004); and follow-up interviews with 30 health visitors, observation of 21 visits where the assessment tools were being used, and follow-up interviews with 19 of the health visitors' clients (Cowley and Houston 2003). The body of work revealed that the health needs assessment tools focused more on medicalised risk discourses rather than being applied as tools to support the identification of clients' needs. In line with these findings, the structure of the tools, it was found, encouraged health visitors to ask questions over listening to their clients, a dilemma which is also explored in policy literature (Scottish Government 2012a). Appleton (2011), in an article about safe guarding and child protection, uses the opportunity to reinforce the importance of health visitor judgement over the use of assessment tools which was evidenced in her research work on health visiting and child protection in the early 1990s. The findings of the research reflect a wider discourse in the health visiting literature expressing concern about the impact of external focused decision-making on health visiting practice.

In support of this viewpoint, a study by Williams (1997) carried out in the 1990s using a qualitative methodology found that while health visitors grappled with the concept of vulnerability they targeted their service on the basis of their local knowledge generated through working with individuals. He found that targeting was done by health visitors within 'a basic minimum service to all' and argues that the study highlights a dilemma faced by health visitors about a policy directive to target services while believing in the importance of universality.

A number of papers commenting on health visiting have identified its longevity as a profession as a key factor when considering its future survival (Brocklehurst 2004; Hoskins 2009). Peckover (2011), through an examination of health visiting in policy discourses

around both public health and safeguarding children, concludes that health visiting lacks a 'meta-narrative', a condition which she supposes may have been an asset which has contributed to the survival of the profession:

Indeed, the lack of certainty or meta-narrative about health visiting may itself be a strength, enabling the profession to adapt itself in response to policy and practice developments. Thus ... it is important to both celebrate and critique the survival of health visiting, which is ever-present, often invisible and probably threatened by future policy and budgetary reforms in the UK (Peckover 2011).

At the same time, it has been suggested that health visiting is in need of stronger theoretical and academic bases (Elkan, Blair et al. 2000; Cowley and Bidmead 2009; Bunn and Kendall 2011; Peckover 2011). This indication has often been in the form of a call from academics from the health visiting profession (Robinson 2000; Cowley and Bidmead 2009; Peckover 2011). While this suggestion may be true, the literature suggests that differences between health visitors' experiences in practice and the dominant mode of inquiry to prove effectiveness could be a disincentive for health visitors considering academic work.

3.4.5 Parenting and gender

Much of the existing literature on parenting tackles its 'complex gendered realities' (Aitken 2000:581), whether from the perspective of family research (Aitken 2000), policy (McKie, Bowlby et al. 2004) or service provision (Fägerskiöld 2006). The majority of the analyses of these gendered realities are based on empirical research studies drawn from samples of mothers as the predominant users of child health services. Men have become the subjects of research almost always only when they have also been the prime source of the social inquiry, either in relation to fathering or their experiences of child health services.

The study of fatherhood has been a topic of interest within the social sciences since the 1970s and has taken many methodological turns as fathering itself has changed (Marsiglio, Amato et al. 2000), with the body of work on mothering also developing with each decade (Arendell 2000). The relationship of fathering to mothering has emerged from studies (Aitken 2000) and has been the starting point in a study which set out to explore fathers' experiences in relation to mothers' experiences of giving birth (Kaila-Behm and Vehvilainen-Julkunen 2000; Toity Deave 2008). Aitken's research (2000) highlights how

media and social studies of fathering use mothers as the ‘benchmark for norms in fathering’ where he suggests:

I am not suggesting that fathering can be defined in isolation from mothering, but I am concerned that the idea of the father is constituted in parallel or in opposition to the idea of the mother and, as such, does not account for the imprecise and hesitant day-to-day work of fathering as resistance and negotiation (Aitken 2000:585).

His study, which was a postal survey with 577 households and then subsequently, 231 and 166 households over three years and 127 in-depth interviews, reveals that, for most people, motherhood and fatherhood were understood as ‘natural’ categories that acted to give meaning to their experiences of parenting and which, at the same time, were ‘woven, unravelled and sometimes detached from the work of parenting’ (Aitken 2000:581). Overall, he concludes that ‘even the most active fathers tend to see their role as “helping out” their partners rather than taking the main responsibility for child-care themselves’ (Aitken 2000:581). Kaila-Behm and Vehvilainen-Julkunen’s (2000) study, with 71 interviews with fathers and essays written by 175 public health nurses, categorised fathers as ‘bystanders, supporter of spouse, partner, and head of the family’ and argued that awareness of this positioning could allow public health nurses to work more effectively with fathers. A qualitative study of 20 fathers, to explore their needs for support given by health care professionals, found that the majority of fathers felt excluded from processes around pregnancy where they described themselves as ‘bystanders: more detached than they expected or wanted to be’ (Deave and Johnson 2008: 631). The term ‘bystander’, used in both Kaila-Behm and Vehvilainen-Julkunen’s (2000) and Deave and Johnson’s (2008) studies, is a powerful metaphor which both describes the positioning of fathers in child health care services and the relativity given to them in relation to mothering described by Aitken (2000) in both social inquiry and service provision.

Studies about mothering tend to be hidden in study findings about health visiting practice where reports are based on samples of mothers. Over and above this, there is a literature which explores mothering in relation to breastfeeding (Schmied and Lupton 2001; Draper 2003) where the boundaries of women’s pregnant and lactating bodies have been explored; and sleep, where gendered experiences are also reported (Hislop and Arber 2003). In conjunction, a developing literature explores how these and other practices shape the ‘good

mother' subjective position of women (Murphy 1999; Wall 2001; Marshall, Godfrey et al. 2007; Payne and Nicholls 2010).

In conjunction with the research literature, the gendered relations of the family have been the topic of policy analysis work. A recent shift in policy contexts to talk around parenting, it has been argued, tells us little analytically about the gendered relations within the family (McKie, Bowlby et al. 2004). McKie and colleagues (2004), through an analysis of *Starting Well* (discussed in a policy context in Chapter 2), show that there is no analysis in terms of gender, either in relation to women and motherhood or of men and the role of fathers (McKie, Bowlby et al. 2004). This commentary is supported by the literature on *Starting Well* which states that 'the relationship that the health visitor forms with *mothers* and other family members' was vital to programme implementation (McIntosh and Shute 2006:78).

Gillies (2007) highlights that there has been a shift in social policy discourse towards recognising the role of fathers in meeting the needs of their children. There has been a general cultural shift characterised by the fathers as distant authority figures, to those who are actively engaged in their children's care. The term 'parenting' is now largely used rather than the term 'mothering'. As Gillies (2007:9) highlights, however, 'discussions of "parenting" can obscure the fact that caring for children remains a highly gendered practice.' The daily responsibility for care still sits mainly with mothers, while, for many, time to father is relative to time in the workplace. She also points out by drawing on the work of Lawler (2000:137) that although the role of the mother could arguably be carried out by men or women, the traits of 'good mothering' are 'distinctly feminised', with services tending to be orientated towards women and likewise, sanctions for when 'parenting' is deemed to have gone wrong.

While professional and lay knowledge, the literature suggests, are different from one another, professional knowledge about parenting is largely privileged over mothering/fathering knowledge through knowledge/evidence of the psy professions (Wilson 2003). Wilson, in her study of the practices of Plunket nurses in New Zealand (2003), explores the boundaries between lay and professional knowledge from a background where:

The notion of child rearing as a scientific endeavour is an underpinning philosophy for those authorities concerned with the welfare of children. This idea replaced the earlier view of mothering as instinctive and originated from the expressed belief that maternal ignorance was responsible for the high rate of infant mortality in the late 1800s (Wood & Ruddock, 1920) (Wilson 2003:284).

She reveals how child health nurses worked to locate mothers within ‘scientific discourses’ through their interest in ‘rational’ advice, with their family being positioned outside of these same discourses (Wilson 2003). The discrediting of other forms of knowledge and expertise, she suggests, is problematic when family and friends are also one of the main forms of support for new mothers. Similarly, Edwards and Gillies (2004), through a study of a sample of parents of children from 8-12 years exploring support in parenting, found that: ‘family, followed by friends, are (still) regarded as the people to turn to for most childrearing issues, with “experts” only providing practical help and advice about long institutionalised areas of children’s lives’ (Edwards and Gillies 2004:627).

Johnston and Swanson (2006) in their study of mothers’ experiences of work and caring for their children highlight the intensity of the cultural messages to mothers around work and caring for their children. The comparative expectations of fathers, they suggest, are much more ambiguous. There is an absent knowledge about fathers’ contributions to children’s welfare present in both professional discourse and in common understandings about caring for children (Johnston and Swanson 2006). This lack highlights that the gendered relations of health visiting and parenting require analysis to understand what this means for the everyday experiences of families and health visitors.

The study of fathers’ perspectives on health visiting has been the subject of a small number of studies (Chalmers 1992; Fägerskiöld 2006). Fathers are constructed through these research studies as marginal and marginalised in health care interactions through ideas of traditional roles and women’s intuitive knowledge allowing them to communicate more effectively about the health care needs of their child (Fägerskiöld 2006), but, that health visiting practice has a complexity to it, not always evident in the literature, where they work with different family members and combinations of family members at different times and in different ways (Chalmers 1992).

The gendered nature of health visiting work remains largely untouched in the majority of studies. The female workforce and women's predominance as the primary carers of young children who interact with health visitors are taken largely for granted as the factors which underpin men's exclusion. This is, partially, constructed as being due to the errant ways of health professionals who fail to include them by placing their main focus on the mother and child.

3.4.6 Lay and professional knowledge on parenting and child care

The relationship between lay and professional knowledge has been a longstanding interest in the sociology of health and illness (Cunningham-Burley and Maclean 1991). It has been suggested by Lawler (2000) that media portrayals of expertise highlight that it may no longer be the realm of professional groups only, a representation which she contests:

... the British media's attention to so-called "crises in childhood" and "crises in parenthood" suggests that there is a pluralisation in knowledges about what children are and about how they should be brought up. All this would suggest that authoritative, expert knowledges are losing their ground as people "choose" familial styles without recourse to any other imperatives than their own beliefs, or, that the proliferation of expertise and various forms of contestation between experts means that "expertise" itself is breaking down (Beck, 1992). ... However, these crises may be more apparent than real ... (Lawler 2000:19).

Lawler (2000:20) suggests there are no signs of the surveillance of mothering lessening. Also, she argues, childhood and motherhood are bound with the disciplinary practices through which mothers become 'good mothers'. Given this, she suggests, what can be said about childhood and motherhood is highly dependent on the 'workings of power' (Lawler 2000:21).

The complex relationships between lay and professional knowledges have been explored through a number of empirical studies carried out over the last three decades, often revealing that a mother's own knowledge of their child is embedded in their daily experience of caring for their child, while professional knowledge is shaped by codified knowledge through disciplines such as developmental psychology and medicine (Cunningham-Burley 1990; Mayall 1991). Although embedded in their everyday knowledge of their child,

Cunningham-Burley and Maclean's (1991) qualitative study with 54 women revealed some striking similarities between the mothers' knowledge and that of health professionals where, similar to the health professionals, the mothers used their experience to decipher what was normal for their child and when there were deviations from this. The potential for professional approaches to contribute to mothers' feelings of competency, highlighted by this study, also point to a close relationship between professional and mothering practices (Cunningham-Burley 1990).

The extent to which mothers' and professionals' knowledge is separate and/or different from one another has been of continued interest as a topic of sociological inquiry through empirical studies. The MMR controversy of the early 2000s acted as a catalyst for a number of studies which explored this relationship (Brownlie and Howson 2005; Brownlie and Howson 2006; Hilton, Hunt et al. 2007a; Hilton, Petticrew et al. 2007b), and highlighted how trust and expertise had been challenged and how parents' perceptions of and actions and decision-making in relation to their children's health have become suffused with risk discourse.

3.5 Context: Risk, vulnerability and child protection

3.5.1 Theorising risk, vulnerability and child protection

The introduction of the ideology that health visiting services should be targeted necessitates a separation and division of the population of children and families into those deemed needing and those whom the state believes to be capable of parenting without state intervention. Risk is a key concept; the interest in which has increased dramatically over the last three decades, and through which a discourse around targeting the most vulnerable groups within populations has developed. The concept of risk has been of theoretical interest in sociology, psychology, childhood studies, philosophy, political studies, nursing, and medicine and has shaped the practices of health visitors, social workers, doctors and nurses.

The topic of risk has largely come to define both the professions whose practices are shaped by risk discourses¹¹ and the ‘vulnerable’ groups which are defined through these same discourses of risk. Discourse from a Foucauldian perspective, Prior (1989:3) suggests, is ‘not merely a narrow set of linguistic practices which reports on the world, but is composed of a whole assemblage of activities, events, objects, settings and epistemological precepts’ (cited by Nettleton 1995:23). Lupton (1995) argues, in relation to health promotion and public health, that just as ‘bio-medical knowledges, discourses and practices create their objects and fields of interest – disease, illnesses, patients and surgical techniques – the knowledges, discourses and practices of public health serve both to constitute and regulate such phenomena as “normality”, “risk” and “health”’ (Lupton 1995:4). Armstrong (1993:400) has suggested that the adoption of risk and risk factors by the medical profession has altered the possibilities for illness by ‘opening up a space of future illness potential’. Skolbekken (2008) in his work on risk and the surveillance medicine has illustrated the extent and speed with which it has rolled forward in the literature of the medical profession; 1,000 articles about risk in the 1960s rose to 80,000 in the 1980s with another 250,000 in 1990-2000 as the medical profession embraced scientific knowledge about risk factors, bringing with it the birth of, and possibilities for, proving the success of preventative medicine (Skolbekken 2008:22).

The dominance of risk as a concept in the medical profession spills over into health visiting but in a different form. For health visiting, the boundaries of practice are different and shift between medicine and social work. In conjunction, a parallel discourse shapes the practices of health visiting and social work around the best interests of the child. Needs are recognised as a medical concept and as ‘there’ if not easy to access through formulaic processes (Cowley, Mitcheson et al. 2004). This debate, however, can become paralysed due to children’s best interests being viewed as an ethic of professional work:

Since children’s “needs” or the “best interests” of the child are rarely spelled out and even more rarely problematised, hardly any conceptual space is opened up within which questions can be asked about the meanings of these needs, of childhood in general, or of the motherhood which is held to meet the child’s needs, let alone answers provided (Lawler 2000:20).

¹¹ ‘Risk discourse’ is a secondary construct which is explored through my analysis of the health visitors’ accounts.

Best interests have been shaped by the United Nations Convention of the Rights of the Child (UNCRC) and are evident in legislation, for example, in the Scotland Children's Act (1995) and the Children and Young People Bill (2012) (Scottish Government 2012g), and have also become a central aspect of research/sociology of childhood (Berry 1998). Due to the perfect/natural ideologies which have developed around childhood, the principle can become a barrier to progressive thought and practice. Mayall (2002:3) illustrates how the child who is understood as 'precious but burdensome' has become positioned within social roles which are subordinated and protected.

Although there is a dearth of health visiting literature on child protection (Cowley, Mitcheson et al. 2004), social work has a more developed literature on the topic (Ferguson 1997; Parton 1998; Ferguson 2001). Parton (1998), through working with a number of ideas of Foucault, argues that 'new strategies have emerged which do not have their central focus either meeting the needs of children or responding to child abuse but the assessment and management of risk' (Parton 1998:6). Parton (1998:7/8) poses a fundamental question which he suggests is at the heart of liberal governance and which is a notable philosophical thread throughout the literature on professions, parenting and expertise:

How can we devise a legal basis for the power to intervene into the private sphere of the family in order to protect children, but in a way which does not undermine the family and convert all families into clients of a sovereign state? Such a question is posed by the demand to ensure that the family is experienced as autonomous and free from and the primary sphere for rearing children, while also recognising that there is a need for intervention in some families where they are seen as failing at this primary task (Parton 1998:8).

How this question is responded to varies with time and place and has changed over the centuries, Parton argues, and is currently 'undergoing significant mutation' as risk becomes the focus and defining feature of professional practice (Parton 1998:8).

The relationship between risk and child protection and expert knowledge and child welfare, with a shift to risk and potential harm, means that 'for the first time, the criteria for state intervention included prediction of what might occur or might be likely to occur in the

future' (Parton, 1998:17). This, he contextualises, in relation to resources, where, resource, risk and professional management of child welfare are inextricably linked:

'... what the current (child protection) system does is provide mechanisms and rationales – however administratively and professionally time-consuming – for controlling demand and thereby prioritising work, and is the notion of risk which lies at its heart' (Parton 1998:19).

Beck and Giddens (1992, 1990) have theorised in their works on 'risk society' that risk is a response to the particular insecurities of modern society (Giddens 1990; Beck 1992). Their works are highly visible in the theorisations of social work academics around child protection and social work practice (Ferguson 1997; Houston and Griffiths 2000; Ferguson 2001; Cradock 2004), as are the theorisations of Foucault (Gilbert and Powell 2009; Parton 1998), and Butler's 'performativity' (Powell and Gilbert 2007). Ferguson (1997) takes up the work of Beck and Giddens in his conceptualisation of risk in relation to child protection in social work practice. He traces the nature of risk and child protection through the 21st Century. In doing this he shows a shift from 'simple modernization' in the period from the 1920s to the 1970s to 'reflexive modernization' in the time since. Ferguson (1997) draws on the theories of Beck who suggests that risk is a response to uncertainties of modernity itself, and Giddens, who draws our attention to the use of risk to make what is 'intrinsically unknowable' knowable through the use of risk calculations (Giddens 1991: cited by Ferguson 1997: 225). Reflexive modernisation, Ferguson (1997: 229) suggests, has lead to 'scientific discourses and expert systems like child protection turning their own principles onto themselves' (Ferguson 1997:229), with the result that when enquiries into child deaths occur, the decisions and failures which come into view are those which have been produced through the workings of child protection systems themselves. He raises a point of ontology where he suggests that child protection systems in the West, through embracing risk discourses, consider child abuse: 'as if it represented an ontological reality that is distinct from how it is socially constructed through professional work' (Ferguson, 1997, 231; drawn from Wattam, 1996). He purports that for progression there is a need, first, to develop mechanisms whereby vulnerable children and parents are empowered to access a child welfare system for expertise and with childcare difficulties, and, that:

... a deep understanding is developed of the profound importance of how professional consciousness in child protection and risk society is constituted in terms of manufactured risk which is known and experienced as risk (Ferguson 1997: 231).

This literature works to locate this study contextually in relation to risk and professional practice.

The social work literature reveals that in many ways the practice dilemmas between the professions are similar with assessment checklists increasingly dominating practice and management sustaining an objectivist paradigm (Parton 1998; Houston and Griffiths 2000). The reality in social work practice, Parton (1998) suggests, is that only those at 'high risk' will get resources and then it will be someone to manage their case rather than other forms of professional work. This phenomenon is also revealed in a recent study by Hogg and colleagues (2012) where they identified that despite health visitors' awareness of parenting need, categorising it in this way was problematic due to diminishing resources and an increasing managerial focus on child protection cases over all families with babies and young children.

3.5.2 Child protection and the health visiting profession

The surprising dearth of literature on child protection and health visiting practice, given the self-professed extent to which health visitors are involved in this work, has been documented (Cowley, Mitcheson et al. 2004; Appleton 2011). It has been suggested that this lack is due to child protection practice being understood as falling only within the remit of social workers and their governing institutions (Cowley, Mitcheson et al. 2004). The language used in the literature reflects the ambiguity and uncertainty around the topic, with the terms to describe families of 'at risk', 'in need', 'vulnerable', 'low risk' (Bowns, Crofts et al. 2000) and 'low priority' (Bowns, Crofts et al. 2000), and confusion in language as to whether vulnerability is something which is experienced, for example, 'families who are experiencing vulnerability' or inherent in families who are 'risky'.

A body of work by Appleton carried out in the early 1990s explores child protection in relation to health visiting practice (Appleton 1994a; Appleton 1994b; Appleton 1996).

In her work she draws on studies from the 1980s and early 1990s exploring the usefulness of checklists and screening tools to identify vulnerable families and expresses her surprise at the lack of empirical evidence around the clinical judgement of health visitors in identifying vulnerable families. Her use of the term ‘clinical’ over ‘professional’ reflects the medical orientation of the review with the emphasis on studies which have explored how vulnerable families are identified in midwifery and hospital settings as well as health visiting and community settings. Her empirical work involved a postal survey sent to 102 practising health visitors with a 57% response rate and 12 in-depth interviews with health visitors. It revealed that vulnerability was an ‘ambiguous and poorly defined term’, which health visitors had difficulty defining. The invisible nature of health visiting work with vulnerable families was self-evident to her as a health visitor herself and through her research: ‘health visitors have a wealth of experiences and knowledge of working with vulnerable families, yet the work goes largely unrecognised’ (Appleton 1994a:1139). An awareness of an emerging evidence-based movement ideologically driven through a drive for effectiveness is also evident in her comments. She highlighted the importance of health visitors being able to, ‘articulate their knowledge surrounding vulnerability’, and discusses evidence which emerged from the three areas she studied to show that ‘vulnerability’ was increasingly being used to decide upon resource allocation (Appleton 1994a:1139). Two years later she reinforced this position by publishing a paper, drawn from the same study, reinforcing again the need for health visitors to demonstrate the value of their work with vulnerable families (Appleton 1996:913). She argues for recognition of the ‘importance of health visitors’ preventative work in this area’ which she believes to be ‘overshadowed by an emphasis on routine child health surveillance and other quantifiable aspects of the service’ (Appleton 1996: 917).

Nearly two decades later, in 2011, she reviews her previously rehearsed arguments within a contemporary context. The article, in the *Community Practitioner*, works to emphasise the ‘importance of a well funded health visiting service in safeguarding and protecting children’ (Appleton 2011: 25). She argues that the issues surrounding how children are protected have remained the same over time, however, practice, organisational and policy contexts have changed. She draws on the research evidence available and uses current research

policy to illustrate the importance given to health visiting work in protecting and safeguarding children and highlights a contradiction that at the same time health visiting is experiencing what she calls 'obstacles', including:

... a depleted workforce, large caseloads, low morale amongst health visitors, on-going financial constraints, little evidence of a universal service, cuts in child protection clinical supervision and a lack of recognition by other agencies of the complexity of health visitors' work with vulnerable families (Appleton 2011:25).

Protecting and safeguarding children must now be (re)framed in the context of these (above) measures, which are also evidence in policy shifts around the pay and conditions of health visitors discussed in Chapter 2. All of these examples are highly suggestive of the processes at play to de-professionalise health visiting (and implicitly reduce the resource burden of the profession on health service budgets).

The papers which are published on health visiting and child protection challenge the dominant discourse of the evidence-based movement that gives value to rational and scientific knowledge. Ling and Luker (2000:572) use three case studies to explore the role of what they call 'intuitive awareness'. This awareness draws on knowledge made available to health visitors through processes of observation and assessment which are subliminal/liminal which are embedded in their practice repertoire over time and with exposure allowing for a depth and breadth of experience to develop (Ling and Luker 2000). A study by Marcellus (2005) uses the concept of relational ethics to work to prove that 'it is possible to have a moral and trusting relationship with at-risk families' as long as it is embodied in 'critical self-reflection' and respect (Marcellus 2005). Both studies give suggestion to making the impossible possible through using expertise and knowledge which is, given optimal circumstances and opportunity, deeply embedded in health visiting practice. Crisp and Lister (2004) in their study aimed to explore the 'professional responsibilities' of nurses in relation to the protection of children and the potential for their involvement in this area of work. They found that there was a conflict within nursing accounts, where their active involvement in identifying child abuse cases sat uneasily for many nurses in relation to their family support and wider public health roles. In their conclusions they advocate that nurses, including and beyond health visitors, should be

involved in child protection activities, and that many of the differentiated roles viewed by nurses to be outside the realm of public health arguably sit within its remit, such as supporting families, education for parents, and the development of services. This study suggests and gives an example of the ongoing resistance of the health visiting profession to child protection work and their struggle to maintain differentiated ground as a profession discussed in Chapters 5 and 8. The puzzle as to why there is a dearth of literature around child protection and health visiting alluded to in Chapter 1, and where resistance from within the profession may be a factor, has some light shed on it through consideration of the work of Hanafin (2004). In her paper she works to deconstruct the role of the public health nurse in child protection work. She suggests that there is a difference between the actual and perceived/expected roles of public health nurses in child protection work. Public health nurses' child protection work, she argues, can be contextualised through an understanding of who they work with, their training and education, and by the breaking down of child protection work into primary, secondary and tertiary protective roles. She uses two enquiries into the 'failure of services to protect children living with their families' to explore how the contexts shaping the practices of public health nurses act against their active engagement in the tertiary protection of children (Hanafin 2004:178). Put differently, she is arguing that the work of public health nurses should be clearly differentiated from that of other services whose roles *are* to engage in the tertiary protection of children, with the role and responsibility, in the main, perceived to be that of social workers.

3.6 Discussion (including gaps and limitations)

Studies revealing the difficulties in health visiting practice that the profession is experiencing make a notable contribution to the literature base of the health visiting profession. The majority of these studies describe what is happening in health visiting practice and being experienced by the profession. While useful, there is a tendency towards under theorising in studies, although there are notable exceptions (e.g. Bloor and McIntosh 1990; Wilson 2001; e.g. Peckover 2002a; Pritchard 2005). The health visiting profession itself is at the frontier of debate about the issues facing it as a profession with high quality debate evidence in its own journal, the *Community Practitioner*, which includes peer reviewed research. While this is the case, the development of an academic body of work

about and by the health visiting profession is problematic as it does not have its own high impact journals, with the content of its own journal being heavily influenced by political and lobbying work (Hoskins 2009). Although it has been noted that the theoretical and academic bases of health visiting are underdeveloped, there are some health visitors, often through Masters and PhD studies, who have made a notable contribution. This input is made through methodological developments as well as in relation to their contribution to health visiting knowledge (e.g. Bryans and McIntosh 2000; e.g. Bryans 2004).

The practice-based health visiting literature provides a challenge to other forms of evidence-base by emphasising the intuitive aspects of health visiting expertise, albeit, with likely limited impact, given the extent and hierarchical nature of the evidence-based movement. The lack of literature, for example, in relation to health visiting and child protection, suggests that the publishing on these topics through peer review journals may only be possible when favoured methods and techniques are used, or, on occasions where the authors provide a critique of it within and through their work (e.g. Ling and Luker 2000).

Until recently, there has been very little research from the perspective of health visitors about policy change on their practice and profession. A number of studies carried out since the advent of Hall 4 have changed this, making a notable contribution to what is known about the impacts of Hall 4, both from the perspectives of health visiting practice (Condon 2008; Condon 2011a; Condon 2011b) and the impact on professional identity (Machin, Machin et al. 2011). Although the surprising dearth of literature on health visiting practice and child protection continues, a number of contributions from well-established academics have made a notable impact on current thinking in this area (Appleton 2011; Peckover 2011).

The majority of studies of health visiting practice from the perspective of users tend to be based on samples of mothers mirroring practice where mothers are, predominantly, the primary clients and users of health visiting services. While it is the case, the samples are predominantly female, because it is mostly women as mothers who are the primary users of services, it would be counterintuitive for social inquiry to develop otherwise. As such, there

is little research with men as users of health visiting services outside of specifically designed studies. Notably, there is little research with groups deemed vulnerable through health visiting practice or about their experiences of vulnerability and/or child protection services. I discuss this absence of vulnerable families in research in relation to research methodology, and more broadly, in terms of its implications for policy and practice, in Chapters 4 and 9.

The existing literature reveals that health visiting practice and profession are closely aligned to the medical and social work professions with their respective knowledge and expertise, overlapping, combining, resisting, and synergising in the published literature.

The predominance of women as health visitors and of mothers as their primary clients provides an opportunity to explore the junctures between health visiting as a female profession working with a female population of mothers, where the accounts of health visitors and mothers form the basis of this empirical study.

In Chapter 4 I consider the ethical and methodological issues in researching a topic of policy and practice relevance.

4.0 Introduction

In this chapter I consider the research methods and processes through which the findings of this study have been generated. The overall aim of this study, as stated in Chapter 1, is to explore how health visiting and mothering practices have been shaped by the implementation of Health for All Children (Hall). In Chapters 2 and 3 I have considered Hall 4 within a policy context and located it, and the health visiting profession, within the academic literature on evidence and effectiveness. In sections 4.1 to 4.5 of this chapter I outline my methodological approach in this study. I consider both my epistemological stance and the ontological considerations shaping the study. In conjunction, I explore issues relating to research ethics and methods which I encountered through the particular context of researching Hall 4 as a policy through practice settings. I consider how, in a bid to explore the gendered relations of health visiting practice and parenting, I have foregrounded the accounts of the health visitors and mothers who took part in the study. In conjunction, I reflect on why I was unable to fully explore and use the policy-makers' accounts in my analysis. Also, I consider the absence of accounts of fathers and vulnerable families in the study. I draw the reader's attention to the considerable efforts made to involve the latter, and reflect on, why, given this, they (presently¹²) remain absent. In line with this methodological limitation, I consider the limitations this brings to the claims this research can make. In section 4.6 of the chapter I consider data analysis. I do this by describing how I carried out the analysis as well as how the findings of this research were generated. I consider how metaphors are used by health visitors to both describe and emphasise how their practices are embedded in observational and relationship work with children and their families. I explore the role of stories and how they are used in mothers' constructions of moral adequacy and at the same time act to expose different forms of vulnerability from those recognisable in contemporary public policy.

¹² In 2008 I collaborated with CRFR artist in residence, Rosie Gibson, to develop a research proposal to address this gap. The proposal aims to use art to create common spaces to explore parenting practices with families deemed vulnerable through health visiting practice. It was not possible to implement this proposal in the timescale of this PhD. I plan, however, to develop this aspect in my future research work.

4.1 My methodological and ethical approach

The study uses a qualitative approach and took place within the Lothian region of Scotland. Initially, discussions with policy-makers and practitioners working in the early years, nationally and locally, were carried out to scope the context for the study. Building on this, 16 health visitors and 20 mothers took part in semi-structured interviews. Topic guides were used in the interviews. The topic guides were influenced by the scoping discussions, existing literature and took an appreciative approach¹³. My aim when developing and in using the guides was to provide participants with both structure and flexibility to explore the implementation of Hall 4 from their differing perspectives. All of the research interviews were transcribed. A reflexive, iterative approach was taken to the data analysis. The findings chapters bring together theory and a grounded analysis of the accounts of the health visitors and mothers.

My epistemological stance recognises that Hall 4 as a policy has been produced in particular social, political and historical conditions where competing and favoured knowledge claims exist (Ramazanoglu and Holland 2002:14). The study recognises that the implementation of Hall 4 must be understood within the dual contexts of health visiting as a profession and health visitors as service providers; and mothering practices as well as mothers as users or consumers of health visiting services. I adopted an iterative approach, through interaction with people and texts relating to Hall 4, to the identification of research participants from different professional and familial groups during my fieldwork. I have chosen to foreground the accounts of health visitors and mothers in my analysis to explore the gender relations of health visiting and parenting work and to consider how they have shaped Hall 4 as a policy and its subsequent local implementation. The study questions the ontological position which constructs vulnerability through a discourse of risk. It recognises that becoming a mother is a vulnerable time in the life course and that any mother can experience vulnerability in response to her changed life circumstances. My theory of power is heavily influenced by Foucault's theory of power/knowledge where they are indivisible and power is everywhere

¹³ The approach taken in the research interviews was influenced by Appreciative Inquiry which is a research methodology with its origins in organisational change. This is discussed further in section 4.4.

(Foucault 1980; Foucault 1982). In my findings I discuss how it is through relations of power that some mothering practices (knowledge) become valued over others. The sanctioning of some practices over others (generated through judgements) acts to divide populations into those deemed vulnerable and those who are not. This, in turn, acts to reinforce practices and divisions.

Jamieson and colleagues have suggested (2011) that:

... decision making about ethical practice should be grounded within an understanding of the specific context in which the research is being conducted (Jamieson, Simpson et al. 2011:9).

My ethical approach in this study has been formed through understanding Hall 4 as a policy process embedded in the relationships and practices of the early years professions. This approach emphasises the context where research practice and ethical practice were grounded in the local knowledge and contexts of Hall 4 implementation in NHS Lothian.

In sections 4.2 to 4.6 of this chapter I explore the ethical and methodological issues of this study.

4.2 Ethics: Researching a topic of policy and practice relevance to the NHS

As part of the evidence-based movement there has been a sharp increase in interest in the relationships between research and public policy in recent decades. Lomas (2000:140) highlights that connecting research and policy demands that we understand research and policy-making as processes over products. Policy-making, he suggests, is not a one-off event 'by a defined small group of actors clustered in a room at a specified time, perhaps until a puff of white smoke is emitted', rather, it is a complex process of interactions between different individuals and groups (Lomas, 2000:140). Similarly, Lomas (2000:141) suggests 'research is not a retail store' where 'researchers are busy filling shelves of a shop-front with a comprehensive set of all possibly relevant studies that a decision-maker might some day drop by to purchase'. Hence, it was the dual processes of policy implementation and doing empirical research, and the relationships between them, that produced a certain set of ethical dilemmas in this research. While these were often 'localised', that is to say,

generated, through this particular research taking place within the context of policy implementation of NHS Lothian, they often spoke to more generalised ethical considerations which have been the topics of academic debate in recent years, for example informed consent, confidentiality and the use of verbatim quotes.

4.2.1 Ethics committees and getting ethical approval

As the number of ethical committees and bodies governing social research within and outside of universities has burgeoned, so a parallel critique of the role of these bodies has emerged in the literature (McAreavey and Muir 2011; Hammersley and Traianou 2012). Hammersley (2009) highlights that, in his view, ‘given that what is involved is ethical regulation, researchers will almost inevitably adopt a strategic approach to completing the (research ethics) form, taking into account what they believe are the assumptions of the ethics committee’. In fact, he goes further to suggest that ‘they would be foolish if they did not think strategically in this context’ (Hammersley 2009:216). This strategic thinking became familiar to me as I both worked to engage with the forms and to ensure that I responded, with clarity, to all the requests for information made of me through these forms and in meetings with the ethics committee. In order to progress my fieldwork, I obtained approval from the local NHS REC¹⁴, NHS Research & Development, the University of Edinburgh School of Health in Social Science Research Ethics Committee, as well as permissions through the Hall 4 implementation group, the chief nurse and clinical nurse managers for the locality where the fieldwork took place. For each of the other professional groups I sought approval through the management of speech and language therapy services, midwifery, social work; and, applied for and received an enhanced Disclosure Scotland and an Honorary Contract within the NHS. McAreavey and Muir (2011:394) describe this as ‘play(ing) the ethics game’. I assumed that the ethics committee would take a paternalistic view of vulnerability and construct my parent participants as (potentially) lacking agency to some extent, where although potential participants may be willing to participate, assistance would be necessary for them to do so, for example, with reading and writing. In contrast, I

¹⁴ LREC Ref: 07/S1102/57.

assumed that the ethics committee would view that my professional participants would have agency to participate as people working in public life.

I found the structured format and responses of the REC where I had to make decisions in advance of the research process hindered intuition and reflexivity. Although I was able to describe a set of eventualities to the ethics committee I was not able to describe *the* eventualities reflecting a 'research design (which was) a continual process rather than being fixed at the start' (Hammersley 2009:215). This was particularly problematic when I came to recruit parents (most likely to be mothers) who had been categorised with an Intensive HPI and who were deemed 'vulnerable' through health visiting practice. Secondly, the preparation of a semi-structured schedule in advance of the interviews (albeit with clauses to explain its fluidity in practice) was premised on health visitors as service providers, with experiences of the implementation of Hall 4 at a local level, which were waiting to be captured through a semi-structured (prepared) schedule. As the study evolved I started to understand Hall 4 differently, in relation to health visiting as a profession. I found that the reflexivity that this required, although possible, was not enabled by the procedures of ethics committees whose approval I had sought.

4.2.2 Gatekeeping: Understanding Hall 4 as about people and relationships

Barley (2011:2) highlights the importance of 'learning how to locate and build relationships' in the early stages of fieldwork as a means of initiating and ensuring on going access. She suggests that by:

... focusing on developing key relationships also allows the research to become familiar with norms and rules. To do this, gatekeepers, who allow initial access to a community, and guides, who can facilitate the development of relationships within the community, once initial access has been granted, need to be identified (Barley 2011:2).

Although my aim at the outset of this PhD was not to conduct an ethnographic study, I found that through detailed observation of the field, and the relationships in the field, I could start to understand Hall 4 as a policy process. This included shadowing health visitors, and meeting with practitioners, most often in their work place, and with key policy-makers who had been involved in the working groups and processes through which the Hall 4

publications had been produced. The research relationships were deeply embedded in the everyday patterns, routines and relationships of community nursing.

During my fieldwork, and later in my analysis, I found that I needed to work reflexively with relationships, power and emotions (Mauthner 1998:48). This involved recognising that the voices of different respondents were shaped by power relations, for example those between policy-makers, health visitors and mothers (in particular the most vulnerable mothers); and listening to my own emotions through the research process. These included emotions inherent in research relationships which can become less visible, for example, trust and respect, both emotions which are central to the research process, and those which were more visible to me and, in all probability, to others, for example, upset and embarrassment (Brownlie 2011). The importance of recognising all emotions, that is those which felt uncomfortable, for example, embarrassment, or anxiety, as well as those which I experienced as less intense, but which were as important, such as those encountered in generating relationships of trust, became central to the negotiation processes around access with gatekeepers and/or the ‘guides’ (Barley 2011:2) in the fieldwork. It would also prove of value in my later analysis of mothers’ accounts and in my reflexivity as a mother myself.

At one meeting I experienced feelings of ambivalence to the research characterised more by the silences in the meeting and exchanges between participants outside of the main business of the meeting. It was through my awareness of my emotional and reflexive responses to the interactions in this meeting that I would later understand this exchange in the context of relationships and where nurse managers were working to protect and illuminate the practices (and workers) in the localities for which they were responsible:

‘... one of the senior managers has flagged up a concern [about study locations] and asked that I come to the next Hall 4 meeting. ... At the meeting, I introduced the research [again] ... one of the nurse managers asked questions about how the study would fit with other initiatives in her patch ... the health managers seemed to be “questioning” the study more than taking an interest in it and what it might offer. The [chair of the meeting] ... suggested that the 3 nurse managers from areas where other “initiatives” weren’t happening should meet and agree on areas [for the research]. I agreed [a bit ambivalently as I felt that it was being taken out of my hands]. When I left the meeting I felt emotionally drained. I felt upset ... a week later, having heard nothing, I emailed and asked if areas had been decided on ... [the

health manager] got back with 5 areas, 3 which were different from the ones I had initially suggested. I felt a sense of disappointment that the decision had been taken out of my hands, alongside, wanting to maintain relationships ... I realised that the managers round the table had an extensive knowledge of their patch and their area which could provide insights far beyond what I could access otherwise. Keeping relationships “open” seems important with this in mind, at the same time I feel somehow disadvantaged as I don’t know why I am being guided to some areas over and above others (Extract from field notes, March 2008).

The complexities of gatekeeping have been well documented with reflections grounded in researchers’ experiences of carrying out fieldwork (Mauthner 1998; Miller 1998).

Participation is often dependent on relationships which can be precarious and imbued with power. These relationships, which require careful negotiation, can include when adults seek the participation of children in research, or when research involving multiple family members recruits participants through existing family networks, for example, parents and children or sibling groups (Mauthner 1998; O'Reilly, Karim et al. 2012). Common concerns which have been written about are that gatekeepers may act to protect themselves and/or others from the harms they perceive participation in the research may involve and that they may promote involvement of others without providing them with information about participation and its potential implications for the participant (Tyldum 2012:203). What has been less well documented is, as Miller (1998:64) highlights, the ‘ways in which gatekeepers, through their relationships with participants, can *continue* to exert influence over whether and how a participant feels able to speak’. The fieldwork generated many issues which I had not foreseen about the relationships between public policy and research processes. I found that the ‘guides’ of the research and my interactions and relationships with them often ambiguous and difficult to read and developed an awareness that my own relationships and interactions while in the field were contingent on a wider set of relationships between Hall 4 implementors, for example, policy-makers, health managers and health visitors; and also between the health visitors and those who were constructed as vulnerable (or not) through their work, for example, the mothers who I interviewed (or not). This tension could result in uncomfortable interactions when in the field as this extract from my field notes shows:

I met with 3 health visitors today and their team manager. As I was heading towards the lift [to go to the meeting room] one of the health visitors came in to the lift at the

same time. We started chatting. Before we got to the meeting room she stopped and said, “Can I just confirm if this is the first interview or just to introduce the research?” “To introduce the research” I said, I continued “It is a chance to find out more and decide if you want to take part in it or not”. She responded [with a puzzled and slightly disengaging look which I read to imply from her following comment that she felt she did not have a choice over her participation], “But we have been nominated” [she shrugged her shoulders] (Extract from Fieldnotes, April 2008).

In this circumstance, the manager introduced the research (as evaluation) and then left the room, leaving the opportunity for a two-way discussion about the research where I could reinforce that participation (and non-participation) would not be discussed with managers, allowing me to feel more confident that the respondents were making an autonomous decision to participate.

McAreavey and Muir (2011:391) have highlighted how ‘the unquestioning adoption of a medical model of ethical review based upon positivist methodological assumptions has created many a mismatch between their ongoing ethical research practice and the process of obtaining clearance from Research Ethics Committees (REC)’. Equally, I found that nurses’ managers, whose practices, the research literature discussed in Chapter 2 suggests, were likely to be being dominated by pressures to prove the ‘effectiveness’ of their workforce’s work, adopted a research language framed in positivism and used it to influence the research methods and recruitment strategy. For example, in negotiating areas for the research, one of the health managers raised concerns that the research would be ‘biased’ if it focused on too few areas as it would be dependent on which professionals were interviewed, embedding the study in their local knowledge, experience and relationships. For me, as a researcher, the study, in contrast, was about an intuitive and interpretivist approach to knowing, more akin to the work of health visitors themselves, hence I found myself working on the same axis between evidence and effectiveness explored in the literature review in Chapter 2.

4.3 Gathering and analysing accounts of Hall 4 implementation

4.3.1 Policy-makers

It was through this time in the field, undertaken prior to the semi-structured interviews, that I started to construct and conceptualise Hall 4 at both national and local levels. At a national

level, through meeting with and interviewing key policy-makers, I began to understand Hall 4 in relation to how members of one profession, that is to say doctors, in particular paediatricians, had influenced the practices of another, who had been charged by the medical profession, and themselves, with its implementation. This understanding was reinforced, and became a persuasive *truth*, through the published documents outlining the findings of the Hall 4 working groups and recommending changes to practice and through my review and analysis of the literature. I would later explore this published ‘truth’ using Foucault’s ‘regimes of truth’ (Foucault 1980:131). These policy-makers, and their accounts of Hall 4, also acted as a gatekeeping mechanism to identifying and hearing the stories of other groups upon whose practices Hall 4 was likely to have impacted.

I also found myself experiencing an ethical dilemma where the purpose of the interviews, which was to access their ‘expert’ knowledge as those involved in the development of Hall 4 as a policy to scope the context of the study, meant seeking *informed* consent which, itself, was problematic. This difficulty was reinforced by the discussions taking place at the start of the research where informality, allowing for curiosity and interest to shape the encounters, was key to their success. As Haggerty (2004:404) has highlighted:

The movement of informed consent provisions from the medical sciences to the social sciences has proved to be a point of contention. At least three downsides to this protocol can be identified. The first is that when used in the context of ethnographies, participant observation, or exploratory interviews, consent forms seem alien, unduly formal, and occasionally unworkable (van den Hoonaard 2001, 2002). Consent forms can unnecessarily color interviewer ethnographic situations, transforming encounters that are routinely more informal and exploratory into unnecessarily official and legalistic exchanges (Haggerty 2004:404).

All the participants gave kindly of their time and thoughts. However, to seek written consent remained illusive when my contact with them was on the premise of accessing their expert knowledge over them being research participants themselves. In the absence of written consent the use of these data has remained informative and influential in my analysis over being used analytically in my findings. This remains an ethical dilemma for me (having ruled out the possibility of retrospective written consent as unlikely to achieve the goal of informed consent).

4.3.2 My focus on health visitors and mothers

My analysis focuses, primarily, on the accounts of the health visitors and mothers. This method has allowed me to focus my analysis on health visitors as the ‘street-level bureaucrats’ (Lipsky 1980, 2010) implementing Hall 4 at a local level and on mothers as the primary users and clients of health visiting services. Condon (2008; 2011a) also refers to ‘street-level bureaucrats’ in her study of health visiting responses to Hall 4. Hence, I am not the first to use this concept in a study of the implementation of Hall 4. Lipsky (1980, 2010) has argued that ‘street-level bureaucrats’ play a crucial role in producing policy as it is their practices which shape the policy at the level of local implementation and which, ultimately, shapes how users experience it. It was health visitors whose practices were the focus of the policy recommendations of Hall 4. The accounts of health visitors, although they play a crucial role in the implementation of Hall 4, are currently published very little.

Table 4.1, below, describes the predominant characteristic of the populations with whom the health visitor respondents worked and the socio-economic status of the mother participants.

Table 4.1: Health visitor and mother respondents

Group	Number	Demographic details
Health visitors	16	3 working in affluent communities 10 working in mixed communities 1 working in a deprived community 2 working with specialist populations
Mothers	20	20 with mothers (2 where the mother and father were both present) 2 household incomes under £20,000 per annum 4 household incomes £20-40,000 per annum 12 household incomes over £40 000 per annum 2 unknown

Recruiting health visitors and mothers to the study was a complex process. The idea that participants take part in research of their own free will and through altruistic motivations has been questioned (Hammersley 2009). Hammersley (2009:214) questions this idea by drawing on an example from Douglas (1976) who:

Criticizes traditional views of research ethics for assuming that society is fundamentally cooperative in character, whereas (he argues) in fact societies inevitably involve conflict; as a result, misinformation, evasions, lies and the maintenance of fronts is a routine (Hammersley 2009).

I often experienced the field as one of conflict where health visitors would use tactics, albeit subtle in their expression, such as call evasion, not returning calls, and deciding (on my and their behalf) whether mothers in their caseloads were 'suitable' research participants. I found that geography, deprivation and vulnerability were closely tied. It was easier to recruit health visitors in more affluent areas compared to more deprived areas. In deprived areas I experienced staff teams who were 'covering' for others, for example, for those in retirement, newly in post and/or large teams of multiple health visitors all working for one or two days and/or short periods of time again to 'cover' areas which were chronically short-staffed. In conjunction, I found that in more affluent areas, health visitors would easily recruit families who were 'users' of their services, but had very few families who they categorised as 'vulnerable'. Alternatively, I found that health visitors were either unwilling to make the connection between me and mothers or would suggest that the 'vulnerable' mothers on their caseload would not be suitable research participants, for example, due to their drug use and being perceived as erratic.

At the outset of the study my aim was to involve fathers and I planned field work with (at least) a small group of fathers as I was keen to acknowledge these voices. My final focus on mothers, however, mirrors patterns of service use in the early years and the gendered relations of caring for children which exist (McKie, Bowlby et al. 2001; McKie, Bowlby et al. 2004). Although I recognised fathers' voices as valid and authentic contributions to understanding the gendered relations of health visiting and parenting, I chose to privilege the voices of mothers as the primary users and clients of health visiting services.

Over the course of the research I interviewed 8 other professionals whose work focused on the early years and who were identified through the research as professional groups whose practices had also been influenced by Hall 4. These included 3 social workers, 3 speech and language therapists, and 2 community health nurses. The low numbers of professionals in each group made analysing their accounts within each profession problematic, however, taken together they provided an analytical buffer to explore ideas and patterns that were developing in my analysis of the accounts of the health visitors and mothers.

4.3.3 Access and the participation of ‘vulnerable’ families

As Tyldrum (2012:200) highlights:

... in much methodology literature, access to respondents is dealt with as an issue of who to include, tied to questions of sampling and population. The issues of how we proceed to access respondents and their stories are often presented as relatively unproblematic.

She ties the issue of informed consent and participation in research to ‘human and social capital’ suggesting that volunteering for research is less likely in those groups with lower levels of these forms of capital. The absence of families deemed ‘vulnerable’ through health visiting practice remains a limitation of the research. The difficulties which researchers have experienced in accessing ‘vulnerable’ groups has been well-documented in the literature (Smith 2008), with a suggestion that the application of some pressure may be ethical on some occasions (Tyldum 2012). The health visiting literature is also dominated by the accounts of service users (Machen 1996), over those who do not access these services. My initial approach, where I hoped to access ‘vulnerable’ families through health visitors, was limited in its success. Although families were service users, in that they had been constructed as ‘vulnerable’ through health visiting work, they were not necessarily using services of their own free will. It was likely that their relationships with services were, the health visitors’ accounts have suggested, shaped by monitoring, policing and statutory obligations. Although it has been possible in the research to ‘imagine’ their voices through the voices of those mothers present, their absence remains a gap and limitation in need of analytical and methodological attention beyond constructing them as ‘hard to reach’ compared to those who can be reached using traditional research tools and methods. In the

study fieldwork I had many failed attempts, for example, telephone numbers no longer in use, people not at home when I went to meet them, or no longer attending a child and family centre through which access had been arranged in contacting women who had been categorised with an Intensive HPI through health visiting work. Despite these difficulties, I did manage to make contact with two women who I interviewed. On both occasions, the circumstances in which I met with the mothers made me question whether the semi-structured interview format (with its structure and formality) was potentially silencing their accounts of caring for their children's health and welfare. For example, one woman was in her nightwear and watching television with her boyfriend and brother when I went to meet her; another had three young children with her battling for her attention and was ready to leave the child and family centre for home.

Both times I experienced feelings that the research 'interview' was not capturing the experiences of these women. Edwards and Ribbens (1998:12) suggest that, 'at times, public knowledges may not be so much resisted as disregarded, either as irrelevant or unacknowledged. Such disregarding might indeed be seen to occur on the basis of different knowledge forms rooted in more privately oriented social settings and experiences' (Edwards and Ribbens 1998:12). The semi-structured interview divided me as researcher from the mothers whose experiences I wanted to listen to. The rooting of these knowledge(s) in, as Edwards and Ribbens (1998) suggest, 'more privately orientated social settings and experiences', suggested to me that this group equally demanded research methods which could respond to this need. At the same time, my own social position as a PhD student could act to marginalise rather than illuminate the voices of less well represented groups (Reay 1996). My response was to work to find different ways to both recruit and listen to the voices of 'vulnerable' families through developing a programme of work with the CRFR artist in residence. This work was not possible within the timescale of this study but remains a goal which I hope to realise.

4.4 The research interview as a form of identity work

Most research methods have emerged from an academic tradition of identifying a research problem where the appropriate research methods are developed to bring meaning to the topic

being investigated (Carter 2006). Appreciative Inquiry (AI) is a research method which was initially used as a tool for organisational change (Cooperrider and Srivastva 1987) before being adopted in the social sciences (Liebling, Price et al. 1999; Greany and Elliott 2001; Reed, Pearson et al. 2002; Michael 2005; Wright, Baker et al. 2005; Carter 2006). Its proponents suggest that it differs from traditional research methods through its focus on what is working best in contrast to problem focused research which can act to fragment and separate the field of inquiry (Carter 2006:50). Researchers who have used AI in their work have been effusive in their praise for the method as a means to search out and build on best practice and optimistic in their critique of the difficulties they had encountered (Liebling, Price et al. 1999; Michael 2005; Carter 2006). During my initial fieldwork and familiarisation in the field, I had observed that the working days of health visitors and their managers were pressured. My aim was to use this method to provide an opportunity for health visitors to explore their practice freely. It has been suggested that the necessary conditions are required to properly hear the stories (Mauthner 1998). In practice, I found that I needed to shift from thinking about health visitors solely as service users with perspectives (and notions of good practice) to be captured and to listen to the stories they were telling within the context of the profession and professional practice. For example, questions which I asked around the relationships that health visitors had with their primary care colleagues were often met with limited responses. Professional differences and boundary negotiations did, however, become evident in the health visitors' narratives about their practice and were reflected in the accounts of the members of other early years professions who were also experiencing challenges to and within their own profession.

While using AI allowed me to think differently about Hall 4, I found that when I met with the health visitors it was through a process of listening and responding that a professional dialogue would develop which allowed for a critical telling of ideas and experiences.

Rapley (2001) has highlighted, how, irrespective of which interviewing approach is taken:

... the "data" obtained are highly dependent on and emerge from the specific local interactional context which is produced in and through the talk and concomitant identity work of the interviewee and interviewer (Rapley 2001:317).

I found, through my interactions with health visitors, that health visiting was in a time of flux. While this was the case, I found that health visitors would use the interviews to ‘perform’ moral adequacy as health professionals through their accounts of their professional work. Work to achieve moral adequacy is at the heart of the interview in that ‘language is performative, it is not merely a neutral means of communication’ (Rapley 2001:307). Rapley (2001) suggests that, ‘Central to this analytic perspective is an awareness of the accounting work of interview talk, that speech-acts are performative, used to “present the self” (cf. Goffman, 1959) in a morally adequate light.’ (Rapley 2001:307). As a researcher, I aimed to maintain a neutral stance on Hall 4. However, I was mindful that there is a difference between ‘doing neutrality’ and ‘being neutral’ (Rapley 2001:316). I also found, as Rapley (2001:316) highlights, researchers have control over the topics, when to introduce them and to ‘guide the talk through’ through ‘questions, silences and response tokens’. Also, researchers are able to decide which part of the interviewees’ talk to follow up:

‘Interviewees can work to hold the floor, either through forecasting that more talk is to come or through rush- throughs (and by producing stories ...) ... and this allows them the space to construct a specific, and often morally adequate, identity in relation to the topic of the talk’ (Rapley 2001:316).

An example of the tensions and ambiguities which health visitors commonly worked with as they talked about their work is evident in the account of HV7, discussed in Chapter 8. She initially pursued a line of response, for example, around feeling that health visitors were increasingly policing and being asked to police families and then, later in her account, reconstructed this in relation to historical practice (i.e. better now than then) and commonly expressed ‘ideals’ of health visiting practice (i.e. to provide families with young children support rather than being present in families’ lives in a surveillance role).

4.5 Place/research location as data

Gillies and Alldred (2002:41) draw on Griffin (1996) to make the point that in our role as researchers it is not possible to become them. What we can do, however, is to ‘tell our story about their lives’ and in doing so ‘make explicit our intentions for telling our story of their lives, and our intentions for the processes of participation, interpretation, and

writing/representation'. The importance of 'place' in terms of the environment in which research interviews take place has been well documented (Hallowell, Lawton et al. 2005; Jamieson, Simpson et al. 2011). The settings in which the research interviews took place were chosen for convenience for the research respondents. During the research analysis stage, however, I found that the settings in which the interviews had taken place – homes and clinics – reflected much of what I was seeing in my data. Gillies and Alldred (2002:41), writing on the topic of feminism and representation, draw on Fraser and Nicholson (1990) when they suggest that one way of responding to concerns about representation is for researchers to 'put themselves in the picture' and through doing so, to provide embodied research accounts. My research experience of being in family homes and health visiting clinics in the research interviews and the observations I made in each setting, for example, of furnishings and family interactions in homes, and the bareness of clinics, acted powerfully to locate me 'in the picture' of these settings – homes and clinics – in which health visiting practice takes place.

4.6 The production of research accounts: from private thoughts to public records

All of the research respondents, apart from one of the health professional respondents, agreed to be audio-recorded. Bancroft (2011), drawing on Actor-Network theory, highlights how the recorder can act to shape the research interview with the switching on and off of the recorder acting as a cue which changes the nature of the relationship between the researcher and the respondent. When the recorder is on the respondent expects their words to be heard by the researcher as part of an official record (Bancroft 2011:73). My experience of conversations outside of recording and of the interview with the health professional who chose not to be recorded suggests that it was likely that the recorder increased their awareness that their account of Hall 4 would become part of official discourse. While this was the case, I found that the research interviews were rich in stories of both professional practice of working with children and families and of mothering practices, suggesting that respondents were operating within a complex conceptual framework of family displays (Finch 2007), performativity (Butler 1999) and presentation of self (Goffman 1959).

All of my research interviews were transcribed. This provided a written record of the interviews within which I was keen to retain the emotion and ebbs and flows of the research encounter. Although it was Hall 4 as a public policy which had framed the research at the outset, it was the nuance of health visiting and mothering practices which were forming the 'epistemological base of everyday knowledge' which was emerging as central to understanding Hall 4 implementation at a local level. Apthekar (1989, 43-44, cited by Edwards and Ribbens, 1998:11) refers to this as 'the dailiness of women's lives' and works to give us insight into how this might become accessible as knowledge:

By the dailiness of women's lives I mean the patterns women create and the meanings women invent each day and over time ... the point is not to describe every aspect of daily life ... the search for dailiness is a method of work that allows is to take the patterns women create and the meaning women invent, and learn from them. If we map what we learn, connecting one meaning or invention to another, we begin to lay out a different way of seeing reality ... dailiness is a process rather than a conclusion; it structures thought.

Rapley (2001:305) showed how, by using the rules developed within conversational analysis, it is possible to capture the role of the interviewer and local contexts in co-constructing the research account. I was keen to keep, as Rapley (2001:309) puts it, a product which was a form of 'deep mutual understanding – the stuff of real feelings and personal ideas and emotions'. Unversed, however, in the rules of transcription for conversational analysis, I chose instead to remain mindful of the importance of both my own (emotional) responses and the interactions between me and the respondents in the co-construction of research accounts. Practically, I did this through writing about these in my field notes and noting them in my analysis, both in terms of respondents' use of language to describe emotion and by reading between the lines as the stories they would tell in their research interviews unfold in the transcripts.

4.7 Confidentiality and 'deductive disclosure' in policy/practice research

Confidentiality through anonymity is assumed to be both desirable and achievable in the majority of cases of social science research. Although, there have been increasing number of challenges to this stance published in the literature (e.g. Grinyer 2002). It was the localised and contextualised nature of the data, however, which characterised the reporting

and confidentiality concerns in this study. The risk of ‘deductive disclosure’ (O’Reilly, Karim et al. 2012:212), ‘that is the recognition of certain characteristics by peers or those known to the participants’ was possible on a number of fronts. In relation to the accounts of the policy-makers and practitioners, their unique nature made them highly open to deductive disclosure. However, they were also closely aligned to public and published accounts of Hall 4, where, through their existence as public documents, they had become public accounts. Secondly, it was not unusual for health visitors to use examples from their practice, which, although anonymised, may (although very unlikely) have become recognisable through deductive disclosure. Researchers have sought to minimise this possibility through the anonymisation of data and not publishing data they believe to be overly sensitive. It has been highlighted, however, that if characteristics are altered to too great an extent the ‘power of the narrative’ and meaning of the stories may alter (O’Reilly, Karim et al. 2012). In this study the stories that the health visitors told were often tools to account for the changes which Hall 4 had brought to their knowledge and expertise, where, arguably, to exclude them, and hence not articulate the analytical story of the research, would be of ethical concern. Equally, to omit the detail of the stories would, as has been suggested, diminish the power of the narrative (O’Reilly, Karim et al. 2012). As a result I have chosen to use the stories, but to do so selectively, and with some measures to anonymise the characters although not to remove all indication of their professional and personal circumstances so as to reduce and invalidate the stories completely.

4.8 Iteration between theory and data analysis

I started my research analysis by looking for patterns and themes in my data. In the early stages of my research I relied heavily on describing these patterns. I was aware that an over-reliance on data description could act through a mirroring process to reinforce existing policies and practices. My aim in my analysis was different to this. It was to be analytical and theoretical. At the start of my analysis I used the software package NVivo to store, retrieve and code my data. I quickly found that my analysis was going to demand intellectual processes which I did not find were enabled by the structures of NVivo. My response was to develop my own processes of noting, fragmenting, emplotment, thinking and writing using my field notes and transcripts and the existing literature (e.g. Dingwall

1977; Baruch 1981). In this way, I found that it was through writing about data over coding it, that I started to develop an understanding of its gestalt (Holway and Jefferson 2000:68). This, in turn, allowed me to work towards my analytical goal.

4.8.1 Identifying words, phrases and linguistic patterns

As I worked with my data I began to identify words, phrases and linguistic patterns which recurred in the health visitors' interviews and to make links between these and the context in which they were used. I noted that health visitors were using photographic metaphors and relating these to their work with families, for example, they spoke about 'getting a snapshot' and 'looking at the bigger picture' in reference to their assessments of the needs of the families with whom they worked. In the later stages of my analysis I would also start to consider how respondents used metaphor to influence and draw attention to a particular way of thinking (Wilson 2003). Initially, however, I started by making connections between the statements the health visitors were making and theory, in particular the work and ideas of Michel Foucault. In particular, I was interested in Foucault's ideas about pastoral power and regard or gaze (Foucault 1977; Foucault 1980; Foucault 1982). I saw similarities between these theoretical ideas and what I was seeing in my data. I noted the observations and talking processes which health visitors spoke about, for example, rapport, and their role in how families became known to them. That is, 'how pastoral power allows us to see the regulatory role of health visiting work, as mothers become the subject and the object of the health visiting gaze' (Peckover 2002a:373). From these tentative beginnings, I developed an interest in how health visitors were using language in their interviews. I worked with this interest and started to explore how language was being used by the health visitors throughout their accounts. This initiated my interest in the use of language to constitute reality and Foucault's ideas about discourses and those which were dominating health visiting practice. In these early stages of my analysis, with hindsight, there was often a separation between the theoretical ideas I was reading about (and seeing in my data) and my analysis being grounded and theoretical.

4.8.2 Working with articulate accounts: finding access points into the data

There is an increasing literature on the role and analysis of silence in research accounts (Poland and Pederson 1998; Charmaz 2002). However, there is less written about working with accounts which are articulate, dense and constructed in such a way to present the person as a rational, coherent self. In the interviews the majority of health visitors and mothers spoke with confidence about practices with which they were very familiar and that were part of their everyday lives. Their flow produced few natural breaks, with respondents often constructing complex, and at times seemingly contradictory, arguments within their accounts. I was aware of the difficulties facing the health visiting profession and that the mothers I was interviewing had, even in the short time since becoming mothers, become well-practised at meeting the needs of their children and were keen to talk about their experiences of this. I was keen to ensure that I gave voice to the health visitors' and mothers' respective accounts. I wanted to capture the zeitgeist of the health visiting profession and the experiences of new mothers interacting with the profession. This, however, led to my analysis being highly descriptive with large sections of data being presented without sufficient analytical work. I was working on the assumption that the interview process would give me access to the subjectivities and lived experiences of the health visitors and mothers (Mauthner and Doucet 2003:423). A later shift in my analysis to thinking about what the health visitors and mothers were telling me through their accounts of their respective practices and experiences of Hall 4 provided the entry points into my data which had eluded me in these early stages.

4.8.3 Working with mothers' stories: what are they telling me?

I became aware as I worked with my data that the mothers were commonly telling me stories when I interviewed them about experiences they were having or had had when caring for their children. A developing literature on narrative analysis has focused on stories and how people use them. Frank (2002:8) suggests that 'the researcher who solicits people's stories does not simply collect data but assents to enter into a relationship with the respondent and become part of that person's ongoing struggle ("a lotta continua") towards a moral life'. The struggle then becomes, he suggests, about 'narratability and legibility' where 'narrative analysis can be a significant model for society that will continue to work

out its moral dilemmas in story form' (Frank 2002). I initially noted that the stories in mothers' accounts most often related to encounters which the mothers had had with health professionals when their child was unwell or had had an accident. My first analytical objective was then to establish whether these stories were different from the rest of the narrative of the mother's accounts and if so, in what way. Polkinghorne (1995:6) suggests that there are two forms of narrative, both of which can be present in research accounts: 'narrative as prosaic discourse' and 'narrative as story'. Narrative as prosaic discourse, he suggests, is 'any data in the form of natural discourse or speech' and through narrative as story he conjectures that 'stories are particularly suited as the linguistic form in which human experience as lived can be expressed' (Polkinghorne 1995:6, cites Ricouer 1986, 1991). I now understood that mothers were telling me about their lived human experiences of caring for their children. This was a pivotal moment in my research analysis as it would later inform my conceptual work around discourse and vulnerability.

4.8.4 Analysis of narratives

McCormack (2004:220) suggests that 'analysis of narratives' is where 'researchers seek stories as "data" and then analyse those stories for themes that hold across stories'. I initially identified four stories from the mothers' accounts. I developed a set of characteristics to use in my analysis of these stories which were drawn from those commonly spoken about in the narrative analysis literature (Riessman 1993; McCance, McKenna et al. 2001). I identified a structure to the story through looking for entrance talk, for example, 'Okay, I'll try and be kind of briefer on this' (M1¹⁵); the beginning, middle, end of the story; and exit talk 'So, in the space of a week we did NHS 24, nurse and paediatrician at the [children's hospital], health visitors, doctor, and breastfeeding support group, and it really felt like, whew, health professionalised out.' (M1). In my analysis I then considered what seemed to have made the participant tell their story, I analysed the beginning, middle and end of the story; the plot; the actors; and interpreted and made conclusions from the plot. When I looked across the set of four stories I noted that each of the mothers had constructed themselves as mothers who cared for the health and welfare of their child first and foremost. I started to make connections between this and the literature I was reading about the 'good mother' subject

¹⁵ M1 is an abbreviation which stands for Mother 1.

(Murphy 1999; Murphy 2003; Marshall, Godfrey et al. 2007; Payne and Nicholls 2010). Initially I overworked this theoretically, believing that all the mothers were working reflexively to be understood as good mothers. I realized this and decided that I needed to refocus my data analysis on understanding the mothers' interactions with the health visiting profession. This refocusing proved fruitful as it provided me with a conceptual development. I now understood that all mothers, irrespective of their HPI categorization by health visitors, were telling me about vulnerability through problematising their interactions with health professionals.

I found that analysing the stories mothers were telling using the techniques I had read about in the narrative analysis literature did not get me to the heart of what they were telling me. They were lived experiences, but discrete stories, told with a purpose in mind. I turned now for inspiration for my analysis to a different literature which also spoke about analysing stories. It focused on the concept of 'atrocious stories' which a number of researchers had used in their analysis (Dingwall 1977; Baruch 1981; Allen 2001; Li 2005). I took up this concept through considering how Baruch (1981) had used it in his analysis. Baruch (1981) produced a framework of six stages of story-telling used by his research respondents to achieve a 'status of moral adequacy' as parents. I started to use these as a set of rules in my own analysis and found a neat fit with the stories that the mothers were telling. This convinced me that the mothers in my study were, like those who took part in Baruch's study three decades earlier, working to achieve moral adequacy through their story-telling about their encounters with health professionals. On reflection, I had been so surprised to see the same patterns in my data that I assumed that the mothers were using their stories in the same way as those in Baruch's (1981) study. This did, however, provide me with my next conceptual building block. I started to think with and beyond Baruch's concept of 'moral adequacy' a process which enabled me to begin to understand that the mothers' (and health visitors') story-telling was purposeful and needed to be understood within and through the historical, social and cultural contexts of this particular study on Hall 4 (Mason 1996:109). At the same time, while my interest in the concept of 'atrocious stories' continued as a thread

in my analysis, I chose to drop the label of ‘atrocities’¹⁶ when writing about them. The stories I was observing in my data were subtle and nuanced. They were about professional and mothering practices which, it seemed, were characteristically caring and about the best interests. The term ‘atrocities’ did not seem to capture this, whereas, the terms ‘moral tales’ or ‘moral stories’ seemed a better fit.

4.8.5 Health visitors as service providers to health visiting as a profession

At the same time as I was working to analyse the stories that mothers were telling, I returned to further analyse the health visitors’ accounts. When I revisited the health visitors’ accounts I found that through their use of language they were constructing themselves as a profession (we) in an oppositional position to the policy-makers of Hall 4 (they) when they talked about Hall 4. This differentiation was important, analytically, in considering the theories of power and knowledge shaping the development of Hall 4 as a policy and its subsequent local implementation. I identified a number of techniques which health visitors were using to tell me about the nature of their knowledge, expertise and judgment. They gave comparisons with parents and members of other early years professions and told stories which focused on middle class mothers who had had a child with a developmental difficulty which they had identified through child development checks. This suggested to me that alternative discourses framing vulnerability were present and that health visitors were using these to challenge the dominant discourses framing vulnerability in Hall 4. They were also drawing on their experience to demarcate their knowledge and expertise as health visitors from other professional groups. I was now able in these latter stages of my analysis to develop my understanding of the historical, social and political nature of the health visitors’ accounts. They were located in a historical context when the practices of the health visiting and the profession itself were being threatened. Their practices were being challenged and they themselves, as a profession, were feeling vulnerable.

¹⁶ In Collins English Dictionary (2003) atrocity is defined as: ‘behaviour or an action that is wicked or ruthless; the fact or quality of being atrocious; (*usually plural*) acts of extreme cruelty, esp against prisoners or civilians in wartime’.

My reading of the accounts of the other early years professionals – that is, the social workers, speech and language therapists and community staff nurses – acted as an opportunity to check and challenge my developing analysis. The health visitors were talking about challenges to their expertise and this was supported by the accounts of the community staff nurses who identified their own struggle in finding differentiated ground within the health visiting profession. In line with this observation, social workers highlighted the need for demarcation between their professional work and what they understood to be the work of health visitors when working with families who were being understood as vulnerable through the practices of both professions. The speech and language therapists equally felt that their profession was dependent on health visiting maintaining its professional ground in the early identification of children experiencing speech and language difficulties. Initially, I found that the small number of interviews within each of the professional groups limited opportunities for seeing patterns in the data. Read together, however, these interviews provided an opportunity to both reinforce and challenge the shift from health visitors as service providers to health visitors as a profession, an element which was becoming the central analytical story of the thesis.

4.8.6 Reflexivity, vulnerability and my own experience as a mother

The role of reflexivity in data collection and data analysis has been well documented (Rose 1997; Mauthner and Doucet 2003), with attention also being drawn to the role of emotion in this process (Holmes 2010). I became a mother myself when my daughter Catriona was born in April 2009. I had completed my fieldwork and was becoming immersed in the data analysis. As my analysis developed I experienced feelings of empathy with the mothers I had interviewed. I now knew how it felt to want to be seen as a coping mother and understood the measures mothers took to ensure this, for example, through attending clinics for weighing babies and seeking approval from health visitors about my mothering practices, such as those around breastfeeding and weaning. I now had experience of managing both my PhD work and life with my partner and baby. I found this both rewarding and demanding and could easily locate my own experiences alongside those the mothers had told me about in their accounts and through their stories which I was now thinking with in my analysis. I felt that I could now see myself in the data and it helped to alleviate my earlier

discomfort of not being a mother myself when interviewing mothers. This was quickly replaced by a recurrent and troubling doubt that I had experienced throughout my research fieldwork and analysis, that the women I had interviewed were not those who were defined as vulnerable by health visitors or policy makers. The policy-makers and health visitors had clearly spoken of vulnerability constituted through a discourse of risk and these women were not part of that. When my son Tom was born, in August 2011, I had a different mothering experience. I experienced difficulties when feeding Tom. This resulted in painful feeding for me and slow weight gain for Tom. I found myself telling my story to others in my social network. My story-telling was my reflexive response to an experience I had found traumatic. At the same time it provided me with a reflexive turn in my analysis. I realised that I, like the mothers I had interviewed, was telling a story of my lived experience of vulnerability as a mother silenced by the more dominant discourses shaping what could be legitimately understood as ‘vulnerable’ within policy and practice. Finding my own ‘voice’ as a mother, and understanding the factors influencing it, had served as an analytical lever in my research (Ribbens 1998:30). At the same time, however, like Ribbens (1998:31), I found that expressing this voice and what it meant analytically in my research would be a continual struggle throughout the research process:

I want to create a space in which I can know my own feelings and desires as a mother (researching mothering experiences¹⁷), but I seem instead to hear a cacophony of voices. Some of these voices are so effective and powerful that they close up any space I may have for knowing my feelings, and they accomplish this without any stridency. It does not seem so much a psychological suppression, as a silent and stealthy subversion (Ribbens 1998:31).

This, however, in turn, has increased my awareness of the similar struggles which the mothers present in their accounts where they, in the constructions of themselves as morally adequate, move between the thoughts and feelings of a good mother where expressions of vulnerability can be compatible and incompatible at the same time. It was through attending to the emotions in the mothers’ accounts that expressions of vulnerability, different from those I was hearing through public and professional discourses, such as those about risk and

¹⁷ Here Ribbens is referring to her experience as a mother, and later, as a mother who was studying motherhood as an academic. I make reference to the ‘cacophony of voices’ as both a mother **and** researcher of mothering experiences, where, I believed, through listening to these ‘other’ voices that the difficulties I was experiencing as a mother were inconsequential. This framing of experience was despite Tom’s slow weight gain over a period of months and the distress my family and I were experiencing.

the need to make the future knowable so as children could be protected, would start to reveal themselves.

4.8.7 Rethinking vulnerability

At this stage in my analysis I felt ready to make knowledge claims about the social relations between health visiting and mothering practices over proposing one of many possibilities (Ramazanoglu and Holland 2002:161). When I revisited my analytical work about the 'good mother' subject I now made a conceptual step which I had not been able to take in the earlier stages of my analysis. If mothers were working reflexively to be good enough mothers, this also exposed the possibility for mothers to understand themselves as failing to achieve this goal. I now understood that the mothers were talking about their lived experiences of vulnerability. I found it difficult to work with because the mothers were using a different language of vulnerability from the one I had noted in the health visitors' accounts. The health visitors used a professional and convincing language about the importance of prioritizing vulnerability where children were, in their view, based on their professional practice, at risk of harm and in need of protection. The mothers were telling stories of their experiences which were going against this prevailing and dominant mode of thought. This had a powerful silencing effect on these women's experiences of vulnerability.

I had had to work analytically with the form and content of the mothers' accounts to be able to conceptualise them in relation to the impacts of Hall 4. This process was similar to understanding the health visitors' accounts in relation to their profession over framing them as service providers, but analytically, presented more of a challenge due to the mothers' experiences sitting in stark opposition to how vulnerability was being spoken about by both health visitors and policy-makers.

4.8.8 Dividing practices

My next analytical step was to make sense of what these other stories of vulnerability were able to tell me analytically. I returned to Foucault's work. In his essay on 'The Subject and Power' he talks about the importance to him of his work on how humans become subject

(Foucault 1982). One aspect of this idea is the authority with which some modes of inquiry take up the 'status of science'; a second is what he calls 'dividing practices', where, through disciplinary techniques, 'the subject is either divided inside himself or divided from others. This process objectivises him. Examples are the mad and the sane, the sick and the healthy, the criminals and the "good boys"'; and the third, the ethical practices through which humans turn themselves into subjects' (Foucault 1982:777). I was now aware through my data analysis that the prevalence of a vulnerability discourse around child protection worked to validate some mothering practices while others were dismissed. The relations of power/knowledge inherent in evidence/science further meant that some practices are evidenced as better than other practices. These were often those which are more available to those with more resources, for example, good quality early years care. Where mothers categorised with a Core HPI did not adopt these practices they worked to diminish their importance and emphasise their exercise of choice in deciding not to adopt them, for example, breastfeeding. This conceptual development provided an opportunity to think about the implications of providing targeted and universal services.

4.8.9 Health visiting practice, profession and vulnerability

The final conceptual development in my analysis was made through developing my understanding about the connections between health visiting practice, the health visiting profession, and vulnerability. In the initial stages of my analysis I understood that health visitors were struggling to identify vulnerable families as they both no longer had the same contact with families and they felt that their expertise had been diminished. While I understood that the health visitors were at the same time adopting and resisting the dominant discourse around vulnerability I had not initially made a connection between this and the health visitors' own professional struggles. The difficulties the health visitors were speaking about in relation to identifying vulnerable families were not only because of the loss of opportunity for contact and of their professional knowledge and expertise. The difficulties and resistances they expressed about identifying and categorising vulnerability were inextricably linked to their struggle as a profession to maintain differentiated professional ground (Dingwall 1977).

4.9 Discussion

Hammersley and Trainanou (2011:384) question the approach to research ethics where they suggest that the prevalence of ‘ethicism’ shaping contemporary research practices and the ‘tyranny of “high standards”’ adopted in ethical practice would do well to take note of the worth of ‘Machiavellianism’ where ‘Machiavelli’ argued ‘that, because of the imperfect nature of the world, they will often have to use means that would generally be regarded as bad, for example war, in order to pursue ends that are good’. A health-related example is how doctors, to enable the health of their patients, may need to do so by pursuing tasks which would be judged undesirable through ‘extrinsic’ values, for example, through inflicting pain, or asking personal questions. While I join Hammersley and Trainanou in their cause for concern over ‘ethicism’, my point of departure is their concern that political aims, for example, those which are feminist and anti-racist, should be put to one side and the primary aim of research should be knowledge production. In this study I have aimed to explore the gender relations which shape health visiting and parenting practices. To do this, I believe a methodological approach which privileges the ‘knowledge’ of these gendered voices is important, as otherwise, it is likely that they would remain submerged beneath those more dominant voices which have informed contemporary public policy, including Hall 4.

The knowledge claims which I can make are both facilitated and limited by the research methods used in the study. Just as the inclusion of mothers provided reflexive and analytical opportunities, the absence of fathers brings limitations. At the same time, while the inclusion of mothers categorised with a Core HPI has brought surprising analytical and theoretical insights to the fore, the absence of those categorised with an Intensive HPI leaves an empirical gap.

On reflection, my desire to be able to say something about my data quickly made me move initially to a process of coding and spotting rather than thinking and analysing. It was by learning to ‘live with the sense of the occasion’, the silences and the interruptions, the rhythms and the flow of the data (Eldershaw, Mayan et al. 2007:136) that I was able to achieve holism over fragmentation (Hollway and Jefferson 2000). At the same time, my initial approach to research ethics was dominated by bureaucracy and due procedure. This

gave way to an approach shaped by the development of relationships of trust which both ensured an ethical approach to those who gave of their time and thought and a firm ground for the research interviews and analysis. It was theoretical reflexivity which provided the tool to do this in practice. I consider reflexivity to be about my intellectual engagement with the data (Maton 2003) as well as a consideration of my own social location and that of the research respondents and the impact on the data collection and analysis (Rose 1997; Mauthner and Doucet 2003). In this way the story I tell in my research findings in Chapters 5-8 is a situated, partial account of Hall 4 located in empirical data generated through my interactions with policy-makers, health visitors, other early years professionals and mothers. It tells an analytical story which could not be accessed by listening to one health visitor or mother talk about their experiences of Hall 4 (Eldershaw, Mayan et al. 2007-126). The epistemological approach adopted in the study has provided an opportunity to challenge dominant political and social thought on the ontology of vulnerability. In doing so it provides knowledge about the implementation of Hall 4 which evidences its impacts and includes, yet goes beyond, potential stigmatising effects on families themselves. The research methods used have allowed for insights which would not have been possible through the use of favoured research methods with which 'best evidence' claims are made, for example RCTs (Elkan, Kendrick et al. 2000).

The four chapters which follow provide an account of the research findings. The relationship between power and knowledge discussed in this chapter are further developed when it becomes the focus of the first findings chapter (Chapter 5). This chapter provides an account of a reflexive turn in the research where understanding of Hall 4 as a discrete health policy and health visitors as providers of services to families with young children shifted to understanding the impact of Hall 4 as contingent on understanding its impact on health visiting as a profession and its relationships with parents and other early years professionals. The constructions of this knowledge are explored in the second findings chapter (Chapter 6) through an analysis of how health visitors construct vulnerability through their interactions and observations of families in their homes and clinics. The third findings chapter (Chapter 7) is based on my analysis of the mothers' accounts. In this chapter I explore how mothers manage and negotiate their children's health. I tentatively challenge dominant discourse on

vulnerability by considering, through close attention to the stories mothers tell and the emotion in them, how these mothers account for their own vulnerabilities when becoming a mother. The final findings chapter (Chapter 8) focuses on the health visitors' accounts of vulnerability, how it is constructed through health visiting work, and how health visitors themselves work to resist these in their practice and as a profession.

5.0 Introduction

In section 5.1 I explore how Hall 4 has influenced health visiting practice. I consider how health visitors use their experience of the pre-Hall 4 child health programme¹⁸ to construct knowledge and expertise. In conjunction, I look at how they consider changes to their work practices since Hall 4 have impacted on, for example, their professional judgement and practices around targeting. I explore how health visitors select and use stories from their practice and draw on and compare their work to three main groups: parents, early years professionals working with children in nurseries, and community staff nurses and health visitors/public health nurses recently or currently training; to account for and give value to their knowledge and expertise as health visitors. In section 5.2 I consider how health visitors used language to position themselves as a profession in opposition to the recommendations made through Hall 4, and, by doing so, set the context for their expressions of the impact it has had on their practice, them personally as health visitors, and their profession as a whole.

5.1 Health visiting knowledge and expertise

All of the health visitors spoke about how their practice had changed since the publication of Hall 4 and its local implementation. The health visitors drew heavily on their involvement in the pre-Hall 4 child health programme to express how their work had changed since the implementation of Hall 4. How health visitors talked about the child health development programme and its impact on their knowledge and expertise varied depending on how long they had been practising health visitors. The majority of the health visitors (14) had been in practice for between 10 and 30 years, with a minority (2) 10 years or under, but not less than 8 years. All of the health visitors who had been in practice for over 10 years demonstrated their knowledge of child health through talking about the child health development

¹⁸ Pre-Hall 4, the child health programme consisted of six child health reviews at 10 days, 6-8 weeks, 8-9 months, 22-24 months, 39 to 42 months and 48-54 months. In 2005, and with the publication of Health for All Children, Implementation in Scotland (Scottish Executive 2005a), the child health programme changed to two child health reviews at 10 days and 6-8 weeks, with other contacts varying between families. In 2011, a 24-30 month review was proposed and is currently (2012) being introduced (Scottish Government 2011a, 2012a).

programme. They drew heavily on child health development theory (constructed through developmental psychology and medicine) in their constructions of their existing knowledge base:

... perhaps not all of the development checks were required, however, they have their merits, and each of the developmental stages, 8-months check, it was a very useful one because of making sure babies were sitting and that their gross locomotor system and all the other systems, but particularly the gross locomotor system was really, they were sitting, they were beginning to be erect, they were weight bearing, and I mean it is a massively important stage ... (HV4)

Weight bearing is another thing, you know, if they don't have that 8-month check then they may not know that they should be weight bearing at a certain age and there might actually be something wrong there. When we see them for immunizations, we are seeing them at a year, so we can check out, just do a development check just with them, you know, are they weight bearing, are they beginning to copy sounds, is there interaction going on ... you know, just to glance the experienced eye over them. (HV7)

The health visitors who had been in practice for 10 years or less also drew on the pre-Hall 4 child health programme, in a different way, to account for the development of their health visiting knowledge. So, even when their involvement in the programme had been minimal, health visitors still emphasised its importance in relation to their knowledge base:

... when I was doing my training we were starting to kind of gear up to Hall 4 but we were doing all the checks and stuff, they were still being done, which was good for me because it gave me the chance to see children at all the different kind of ages, whereas now we tend to find it's mostly families with younger children that we're seeing. (HV12)

Although it was their involvement in the pre-Hall 4 child health programme that allowed the health visitors to develop their knowledge of child development beyond a theoretical understanding, it was through their ability to interpret what they were seeing that they made distinctions between their knowledge and that of other people. Health visitors placed emphasis in their accounts on the importance of experience and their ability to make distinctions between what was and what was not important for a child's development (see HV4 and 7 above). They frequently used the term 'we' to refer to health visitors as a collective and by doing so made a distinction between health visiting knowledge and

expertise from the knowledge and expertise of others, for example, parents and nursery workers.

Many of the health visitors highlighted their role as referral agents to specialist services emphasising that it was their knowledge and expertise which enabled these referrals to happen:

... they say we don't need to do these, you know, but it was a contact, and we, most of the hearing screening we did at 7 months and pre-school we used to pick up things and most of the children I referred there was a problem ... (HV11)

And the other thing is that when I used to do vision checking, all of the referrals that I made to ophthalmology, the children came back with some vision defect. So, that kind of proves that it was necessary. (HV8)

The health visitors' accounts suggest, however, that it was not only through the pre-Hall 4 child health programme that they had developed their expertise. The health visitors spoke about the pre-Hall 4 child health programme as a basis for contact with families and it was the contact and the interaction it generated which were fundamental to them both knowing families and developing and maintaining their expertise. Health visitors highlighted that the pre-Hall 4 child health programme provided the opportunity to see all families and formed the basis for the provision of a service which was centred around the needs of individual children and their families:

I know they said that the screening, the reason for stopping it all was because ... [the cases] that were picked up were not worth the total screen but they've left nothing in its, well sort of left something in its place but it's not working and I feel that the postnatal depression, it doesn't always kick in, in the first 6 months of you seeing somebody and often when people go back to work ... 6 months people are having a year now off, but a lot can change. (HV15)

... it comes back to that universal thing, if you're calling everybody in at 2 [years] to do an assessment, then 99% of the people will turn up so ones you're chasing are the chaotic ones and, you know, the ones where you've got concerns about anyway. But you've seen all these other kids and any of them that may have a wee bit of a problem with something you're obviously seeing to that. (HV14)

While the child health development programme provided health visitors with the opportunity for contact with all families, they rejected individualistic notions of child health

which focused on developmental difficulties in favour of understanding children's development in the context of their wider parenting and home experiences:

I can understand the theories behind it, and most of the checks we were doing - that we were seeing well children. I think even still if you are seeing well children I think there's a lot of health promotion advice that we could give to parents and we would tend to find that at certain checks there would be certain issues that came up around toilet training, all these kind of things, so we were able to offer parents some kind of support and advice with dealing with these things, whereas now we don't really see a lot of older children. We find parents are not really tending to phone us so you're thinking well, where are they going with this? (HV12)

And then at 2 [years] it was a fabulous time to talk about parenting because the "terrible twos" are kicking in, or have kicked in already, but it was an opportunity to speak about parenting, it's an opportunity to assess the language development, to check their eyes, to generally talk about whether they are being toilet trained or not and to talk about that so it's a good time to take a rain check on their development ... (HV15)

The loss of these aspects of their practice (e.g. around parenting and understanding child health through their observation and interactions with children and their families in homes and clinics) was a defining characteristic for health visitors of how their practice had changed since the implementation of Hall 4. These changes in their role, they felt, had impacted on their knowledge base and consequently would have implications for them as individual health visitors and for their profession:

*CK: ... What do you see as, are there any particular challenges that you see in relation to Hall 4 in terms of challenges for you as a practitioner?

*HV3: I think de-skilling yourself, because you are not doing the check-ups. I mean, I know you can pick it up quite easily. But you are not seeing the children to do speech reviews, you are not seeing them to do, to find out if they are toilet trained, or how they are doing, or how their sleeping is doing. So I think a lot of these things could kind of, I think been dealt with a lot earlier than perhaps they are. Because they might be going to nursery and the nursery teacher saying, "Oh, this one's speech is bad, and can we get a hearing test done?" So I think things get delayed. (HV3)

So, I feel that we have lost that [input for parents whose children are experiencing child development difficulties], that we are not picking up the speech problems, or the behaviour problems, because again, that is often when you pick that up around about 2 ... (HV6)

Health visitors expressed concern that their knowledge of families and their circumstances had become less responsive since the implementation of Hall 4. The pre-Hall 4 child health programme had provided opportunities for contacts allowing for health visitors to develop relationships through which they could respond to families in a timely way. The loss of the contacts, and the concurrent loss of relationship-building opportunities with families that these provided, made timely and early responses less likely and later responses to more critical circumstances more common:

*HV13: ... let's see the worst case scenario that you met a mum, and it's probably rare, but it's possible ... you met a mum, a young mum who seemed to be doing really well and, you know, I'm trying to think of scenario and trying not to be too exaggerated about it ... she's really impressed, went along to the groups and so on but then the groups end anyway and you think everything is fine, and baby is fourteen months and she goes and meets some chap who she falls madly in love with, because it's nice to have somebody to look after you, you know, and it turns out he's not quite as nice a person, or as safe or helpful to the family situation and ... I don't know, whatever scenario, you know, whether domestic violence, whether introducing to drugs and things ... I'm just not sure about, you know ...

*CK: Yeah, just about a change in family circumstances ...

*HV13: Yes that's right yeah, and what opportunity do you have to pick that up, unless it comes to maybe an incident, a critical incident, does that make sense? ... and that's not what we want. (HV13)

While knowing about the changing circumstances of families was constructed, by the majority of health visitors, as a central aspect of health visiting practice, it was also resisted when framed and understood as child protection work (see Chapter 8 for more discussion on this theme).

The health visitors' expressions of expertise around child development were galvanized through their comparisons of their knowledge base with that of other people involved with children and families. The majority of the health visitors used these comparisons in their accounts. There were three main groups which health visitors drew upon when comparing their knowledge: parents; early years professionals working with children in nurseries; community staff nurses and health visitors/ public health nurses recently or currently training. Each of these groups had been identified in Hall 4 or in concurrent policy on community nursing as alternatives to health visitors as people who could identify

developmental difficulties in children, and as such, were strategic choices by the health visitors used to demonstrate how their knowledge and expertise were different. Essentially, it was the contact and interaction that health visitors had with, not one or two, but many children of different ages and over time, activities which underpinned their expert knowledge and differentiated it from that of parents. They expressed this expertise in a number of ways. First, they accounted for it as being more objective than parents:

... they are not child development experts, they often don't see, or if it is your child and you feel something is wrong, you sometimes don't want to see that there is a problem, so you ignore that. And sometimes that is where we could help in picking up things. And it didn't need to be difficult ... you know, it could be speech, or it could be hearing or, all of these wee simple things that are easy to provide some input for. (HV6)

This objectivity, however, had a distinct nuance to it. So, although they felt they were able to be objective in a way parents were not, they suggested in their accounts that they themselves were not necessarily objective. In fact, to the contrary, they presented their work with families as having a strongly subjective component (more on this in Chapters 6 and 8). What their position as health visitors did allow, however, they suggested, was an ability to say when a child was experiencing something which was different and potentially problematic, based on their knowledge of children's development gained through working with (potentially) all children under 5 years of age:

... I have an element of concern that we're making assumptions particularly... not always, but maybe more frequently with first-time parents that they understand developmental milestones, if that makes sense. Now the scenario I am going to give you is, we've made such huge progress in detecting, for example, delayed speech, and in worst case scenarios potential communication disorders, and I've had experience myself of picking up quite early, and you know it's about being timely, you don't want to be too early because children are all very different but, if you're not seeing all the children at two then that responsibility in terms of developmental milestones is very often missed. Obviously with speech that onus is on the parents and they may not even be aware what's abnormal or not, because if you've not been a parent before and you don't really have a lot of contact because, you know, you just don't have contact with lots of other mothers, how do you know what is normal and what is not? (HV13)

In this way health visitors accounted for their knowledge as being different from that of parents, not solely because it was more objective, although they viewed this to be the case,

but because they could be a judge of normality, a skill which was made possible because of the breadth and depth of their knowledge and expertise of child development.

A further way in which a few of the health visitors constructed their knowledge as different from that of parents was through the use of stories. These were evident in the accounts of HV1, 7, 9 and 15. These stories had characteristics of the moral tales discussed in Chapters 4 and 7 (Dingwall 1977; Baruch 1981). All of the stories had a similar plot. The characters were a child who had experienced a development difficulty, a parent who had not identified the difficulty, and the health visitor who had. The parent in the story was almost always spoken about as the mother, and was positioned through dominant policy discourses to have sufficient expert knowledge herself through her social positioning and education to access help for her child when required. Choosing these stories over others they could tell in their accounts, was another way health visitors constructed their expertise and allowed them to differentiate their knowledge of child development from that of the parents of the children. These extracts from Health Visitors 1 and 15 provide examples of such stories:

I had a [health professional], who had the most awful trouble with, her daughter couldn't speak properly, and she would not accept it, she wouldn't even let me refer the child, and I finally said I was going to put her on a FIN [Family in Need] file, just simply because I said I had to have somewhere to record the fact that she was refusing my advice, and then she agreed to it, and the child ended up having extensive speech therapy that went on for years, but, you know, parental expectations can be too high, they can be too low, they can be blinded. (HV1)

I had a very articulate mother, she was a [health professional] with [name of place], she'd done some [children's] training, I don't know exactly what she did and her child came in at 8 months and it had cerebral palsy, it had brain damage and she was either emotionally blanking us, so she didn't say it because she didn't want to or she just didn't see it and if that child hadn't been seen for that 8-month check, you know, I don't know when that would have been picked up and I know that is only one example and you are seeing hundreds of people coming through but there's nothing ... (HV15)

The stories chosen by health visitors allowed them to illuminate their role in identifying when children are experiencing difficulties. This was possible through their particular knowledge and expertise of child development.

The second group of people that health visitors compared their knowledge with in their accounts was early years professionals working with children in nurseries. The nature of health visitors' accounts of how their knowledge differed from early years professionals also diverged from that of a parent's knowledge of their child. Whereas parents were deemed to be too close or lacking objectivity of their own child and without experience drawn from working with large numbers of children, these same arguments could not hold for this group. Health visitors drew on different examples, drawn from a range of sources including conversations with colleagues, documentaries and conference presentations by education professionals such as head teachers. They used these examples to illustrate that children were reaching school, having attended nursery, with developmental difficulties which had not been identified and which were believed to be impacting on their education:

... you're assuming that people at nurseries ... that other professionals will pick them up. And it's already been shown, you know, got a few head teachers on about this, this week that there's kids going to school who their speech and language is clearly – they're developmentally delayed because the nurseries and things aren't picking these kids up. (HV14)

... it's easy to erode away the role of the health visitor because you don't know what you've lost, but from my point of view I feel – like we were saying about on the television where somebody's discovered all these children going to school with huge language and communication problems, well of course they are, because nobody has been saying that to them, and nobody's ... health and education are all meant to be married up. It would appear that children are going to nursery and nobody's quite picked up that they are meant to be screening these children and referring them on. So there's a big hole in the service and all these children have fallen through, so from that you are not screening any more. (HV15)

The health visitors' accounts suggest then that although early years professionals working with children in nurseries were potentially well-placed through their contact with children to identify difficulties, they had not found this to be happening systematically in practice. Health visitors used anecdotes they had gleaned from different sources, for example, from news reports or talking to colleagues at conferences to highlight that they felt that it was likely that where health visitors were no longer involved in identifying developmental difficulties children were experiencing, education had not necessarily picked up this area of work or at least was not referring on, or back, to health professionals. The health visitors, by talking about what is now not being done, were highlighting both what their role was and the

importance of the knowledge it generated for both individual children, in terms of their health and development, and potentially for their and our collective knowledge around children's development, health and welfare.

Health visitors also drew on conversations they had had with other health professionals such as General Practitioners (GPs) in their accounts as they worked to make the point that their knowledge and expertise was different from other groups of people and had value which had not been given recognition through recent policy developments (including Hall 4), a lack which had impacted on their practices:

Doctors have experience in sick children, but we have experience in what is normal. (HV1)

As one of the GPs said to me, he said, "Every other age, you know, they are encouraging every other age to get screening, whether it be cervical screening, breast screening, yet they are taking all the screening away from children, you know." (HV3)

I think the GPs are finding that if the children are healthy they're not really seeing them at all. There are certain things coming up, like we're doing our preschools just now and we've seen a few children where we're a bit concerned about their speech and they're due to go to school after the summer and really, you think there are a few things are not getting picked up, probably. (HV12)

The third group with whom health visitors compared their knowledge was community staff nurses and health visitors/public health nurses recently or currently training. This comparison reflected wider shifts within policy towards a public health role for health visitors and to community teams where community staff nurses worked with health visitors, taking on some of their roles and responsibilities, but with lesser training, pay and conditions. It was through these comparisons (often using a very modest language, e.g. 'it might take them just a *wee* while' HV7) that health visitors accounted for their knowledge as being experiential and based on a professional wisdom which required experience and opportunity for reflection to develop:

You know, and I think a lot of health visitors that are just maybe training now haven't done routine development clinics to compare to see what's normal, or to compare the range of normal, so it might take them just that *wee* while longer. The public health nurses now, not health visitors. To see enough children to see what is

developmentally normal, it takes a wee while, because it takes a wee while to see enough of the variations to know how big the variation is, to get a feel for development issues, and to know when to start worrying. (HV7)

I know people are saying, screening doesn't pick up, but if you pick up one, and as a health visitor, and even as a community staff nurse coming on, you got to know your normal children before you can pick up any deviations from the normal. And if you are adept at that process, then you can pick up even the slightest deviations from normal, there is only so much you can learn from books. And just because a child is not stacking bricks up doesn't say he can't do it, you have got to be able to look at the whole picture, and he just maybe doesn't want to do it today. Or maybe he is brewing a wee illness or that sort of thing. (HV9)

The health visitors used the concept of normality, which they were in a position to judge through having expertise in child development, as the central and defining feature of their practice before Hall 4. They drew on their use of tacit knowledge and suggested that these judgements of normality could not be made by any person or by objective means. It was through an acuity of awareness, that was enabled by their experience and learning as health visitors, that made their professional judgements both possible and morally acceptable.

The health visitors' accounts suggest, however, that their expert knowledge was not solely experiential. The majority of health visitors suggested it was also premised on having accessed codified knowledge through taught experiences in further education and facilitated by the sharing of knowledge with other health visitors who had also engaged in similar learning. The health visitors used these comparisons in their accounts to highlight the impact they were experiencing of the changing nursing structures on their profession:

... there are still so many things that only a G grade can do that it's a lot more stress for the G grade, for instance, child protection issues or overall responsibility, etcetera, etcetera, and where there used to be two Gs or a G-and-a-half there is now only one G and then a staff nurse who needs to be trained in everything that it took us to do a year's course in, we had a year's course in how to be a health visitor and that, as far as they possibly can, managers are trying to bring them in with Paediatric background if there are any, with any Paediatric or community background, but they then have to get trained up in every aspect of our work to be able to do things that they can do, and they don't want to be just dealing with a task, they won't get much satisfaction through just dealing with a task, and not building up a rapport, or a sort of case load if you like, you know, so staff nurses are not sure either where it is going to go for them. (HV7)

... the other thing is the students coming out are not going to have any experience in the so-called normal child which was one of our strengths. ... And when you qualify, because most of your learning, to be honest, started afterwards, and you were usually worked with an older, more experienced health visitor who acted as your mentor. But these days, I mean it is going to end up that there is only one health visitor per population, so many in the population, and they will probably be so busy doing child protection and the vulnerable families, that the normal people will have got lost, well and truly. (HV1)

Health visitors drew on these structural changes to illustrate the wider impacts of change on their expertise. In doing so they demarcated their knowledge as health visitors from other health professionals who had not received the same educational and experiential opportunities. They also demarcated their knowledge from other health professionals such as GPs. The tension in the health visitors' accounts in relation to child protection work, where it was at one and the same time resisted and adopted as part of their expert practice and viewed to be an aspect of health visiting which others with less training and experience were not in a position to undertake, suggests this role occupies an ambiguous position for health visitors in their practice repertoire. Child protection work is seen to be both responsible work and potentially not the work of health professionals and, at the same time, it is being subsumed into health work as health workers look for new professional terrain with shifts away from concepts of normality underpinning health visiting practice with the loss of the child health development programme.

5.2 The impact of Hall 4 on the health visiting profession as a whole

Health visitors spoke about the implementation of Hall 4 as having personal and professional implications for them. Health visitors often used different pronouns in their accounts to juxtapose the policy and evidence-based premise of Hall 4 with the experience of the health visiting profession. Different health visitors used the terms 'he', 'they', 'Hall' and 'Hall 4' all to describe Hall 4. This contrasted in their accounts with their use of a collective 'we' to describe their position as health visitors who were part of a health visiting

profession. Hall 4 was referred to in a first-person context in a few of the health visitors' accounts, when it was it was a gendered 'he'¹⁹ which they used:

I think as health visitors we all felt quite, found it quite difficult because what Hall 4 was saying was that a lot of the work we had previously done was, basically, not worth doing, because it hadn't been proven to have results. (HV6)

And we are already starting to notice from our nursery colleagues that since Hall 4 has brought in his wonderful ideas of no contact because he said we didn't pick up enough things to justify the service, there seems to be a steady rise in the number of language problems and things like that with nurseries. (HV1)

... he thought what we were doing was really good, but he said as an absolute minimum we could do this and it's amazing, everybody went for the minimum. ...they still want all the protections and they want all of that still there... but with minimum framework. (HV14)

The health visitors drew on examples from their practice and used terms to express their emotional responses to Hall 4 such as 'disappointment' (HV6), 'sarcasm' (HV1) and 'amazement' (HV14) to emphasise the impact of Hall 4 on both their practice directly and how they had experienced these changes to their practice as a profession. All of the health visitors, in different ways, challenged the discourses dominating evidence-based practice – what it is and what constitutes evidence – through the use of their own evidence gathered from experience as practising health visitors. The above extracts (HV1 and HV14) evidence the two aspects of practice through which health visitors constructed their expertise – around work which they broadly talked about in the context of children's health and development (dominant in the extract from HV1) and around work which, if broadly categorised, would and could be understood as child protection work (present in the extract from HV14).

Health visitors also used language to express their emotional responses to how Hall 4 had affected them personally and as a profession. This varied across accounts in relation to the extent the health visitors used this language and the emphasis they placed upon it. Health visitors used terms such as 'saddened', 'distressed', 'disappointed', feeling 'vulnerable', and

¹⁹ It is likely that the use of 'he' was partly in reference to one of the authors of Hall 4 – Professor David Hall – who, as was highlighted in Chapter 2, is most often spoken about in policy and practice contexts as the primary architect of Hall 4¹⁹.

that their work had been ‘rubbished’. In the interviews, from which the following extracts are taken, the emphatic tone and expression used by health visitors was notable. Health Visitor 8, for example, uses irony in her account where she draws on a policy discourse which prioritises children’s health yet which disregards health visiting expertise which is both available and, in her view, being compromised in this very same area:

... we seem to have forgotten the Q word, and that is Quality. We can’t have a quality contact. And I know that their hands are tied and I know that there is nobody to employ but nowhere is anybody saying, actually these are fairly minimum standards here and are we actually achieving this. I don’t feel there is anybody in our corner saying, “This is unacceptable.” The Scottish Exec are saying, Health for All Children, and how important child health is, and reducing the inequality gap, and, and, and, and, the people to deliver it are us, and there isn’t anybody of us, and it is distressing that nobody cares. And so our sickness rate will increase, and people who can take early retirement will, and so it goes on. (HV8)

The majority of the terms used by different health visitors acted to support their accounts of Hall 4 as having impacted on them as individuals and as a profession collectively in a way which they did not welcome or believe to be in their interests or that of children and their families. Accounts suggest a symbiotic effect between the personal and professional impacts of Hall 4:

*CK: ... to look now at some of the issues around Hall 4. I suppose first of all, how do you feel about your role since Hall 4 has been implemented? What is your experience of it, how do you generally feel about your health visitor role?

*HV4: Well, it has changed dramatically. And on a personal basis for me as a practising health visitor for quite a long time, I think it is disappointing from a personal job satisfaction point of view. And I think it is disappointing from a client point of view because we are now not providing a service which I think was extremely valuable, and by that I mean the routine development assessments. (HV4)

Health visitors also drew on examples from their practice, in this case telephone calls they have received from mothers, when they spoke of a health visiting service and profession which they felt was now diminished to support their position as a valued profession. This contrasted with how they spoke about feeling that their knowledge and expertise was otherwise being undervalued through recent policy developments:

I feel saddened. I think it’s an erosion of the service really. I feel that people were getting a good service and often mums have been phoning up and have asked, “Are

you not seeing such and such at 3?”, but ... the new first-time mothers coming in don’t know what they have not had so they are not going to miss it. So it’s easy to erode away the role of the health visitor because you don’t know what you’ve lost ... (HV15)

I think, to be quite honest, I don’t know if I would manage all the check-ups if I was still doing them, with being on my own with the case load you know, with the kind of case load that I have got. It would be quite difficult. Is it a benefit? I don’t know. Is it a benefit to the kids? I don’t know. [Pauses.] I would probably say no then. Well, for practitioners, I would probably say no, because you miss the contact with children, you miss, you will get mums phoning up and saying, “Can you remember me?” And I will say, “Of course I can remember you,” I might not have seen them for a couple of years, but I still know who they are ... (HV3)

As the interviews progressed, health visitors drew on a range of policy directives, particularly around community nursing and child protection, to illustrate the collective and synergetic effect which they were experiencing as a profession as a consequence of the changes encapsulated in these:

I think it has been totally eradicated just about. I think we all kind of feel vulnerable that things we did in the past have all kind of been rubbished, you know, you don’t need this, you don’t need that, and for years and years and years we did it. And I know things change and you have got to move with the times, but it can be quite demoralising, I think. I think the whole service is quite demoralised with all the changes, not just Hall 4. You have got Hall 4, you have got the [new assessment tool²⁰ which has been introduced], you have got the community nurse coming in, so I think we are all feeling a bit, gosh, what are we going to do? Where are we going to go? (HV3)

I think one of the things that it has hauled up to me, is that I have been going Hall 4, Hall 4, but really there are two different, I think there are just certain ways that things came in together. Hall 4 took away things. And, the [assessment tool] imposed things, and I think in a way I have got them jumbled up in my head. So, the minute someone says Hall 4, my back goes up. Whereas it is not really just Hall 4. I mean, I am very, again, it strikes me it is one Hall too many. And that is really what I honestly believe. He should have stopped when he was ahead. Because I had no qualms with what he was saying in previous ones. It is just this last one that I think, you know. (HV1)

²⁰ This is referred to as an ‘assessment tool’ rather than giving it its localised name to enable comparisons with assessment tools used in different localities. The majority of health visitors spoke in their accounts, in different ways, about this tool having a child protection focus. This is discussed in greater detail in Chapter 8.

The health visitors expressed a palpable inevitability about the changes they were experiencing and the impacts which they were having on them personally, their profession and the children and families with whom they worked:

Hmm, bringing in Hall 4 doesn't appear to have made any difference to the number of CHSP forms we get sent. I mean there are still loads and loads of those, and they are not particularly helpful pieces of paper I have to say. It is difficult, because I suppose now that you prioritise, and actually whether it has coincided with the introduction with Hall 4 or whether it would have happened anyway, and I suspect it would, we are prioritising now to the vulnerable families. They are taking up far, far more of our time. The whole way that vulnerability is dealt with and child protection, so actually if we still had all these checks to do as health visitors, it would be largely impossible. But, whether that is a good enough reason to have stopped doing them all, I don't know. (HV10)

A strong aspect of the health visitors' accounts was the tension between work they broadly categorized as children's health/development and work which they saw as focused on children's protection. Most of the health visitors at one or more points in their interviews drew on their nursing backgrounds and/or reasons for entering the profession to illustrate their professional preference for work which focused on children's health/development. One way which health visitors did this was to differentiate between their expertise and motives for entering health visiting and with the work of other professionals, such as social workers:

... we do a lot of child protection in the health visiting service, that over time, especially given the community health nurse review, [unclear reference to social work service], not if I can flipping help it. You know what I mean? That is not where I am from, you know I am health, health, and I came into health visiting because I was interested in public health. Where did that go? (HV16)

... it's sad because I think that we're getting really focused into child protection, which we're all involved in, you know, but none of us want to be social workers and because of all these priorities and something that's happened, it's like a role we're getting sort of pushed into. ...We're supposed to be dealing with the normal children. And ... the health promotion which health visitors used to do. Like the preventative, we used to go and talk to groups which you can't do now. So from something that was universal and hit a lot of boxes which highlighted things. We've been gnawed and gnawed and we're not using our skills to the best that we could use them. (HV14)

The boundary between health visiting and social work was evident in the majority of health visitors' accounts, and was often used to demarcate what they understood to be the roles/responsibilities of the health visitor to those of the social worker. A tension, as previously highlighted, did exist in that work which health visitors spoke about broadly as child protection was prioritized by them and held onto, even when there were opportunities to discard tasks/roles to colleagues with less education/experience. They were talked about as in need of prioritizing and in terms of responsibility. This tension evident in the health visitors' accounts will be explored in detail in Chapter 8.

5.3 Discussion

In the interviews, the health visitors suggest that their knowledge and expertise has been eroded and has shifted focus. Their accounts suggest an erosion of their knowledge and expertise around children's health and development and a shift towards a focus on child protection/children's welfare. While health visitors talk of their resistance to child protection work at the same time they suggest that it is responsible work, which must be prioritised, and which demands expertise. In this way they appear to both resist and be drawn towards this area of work.

The work of Dingwall (1977) may assist in understanding this contrast. In his ethnographic study of health visitors who were training, he showed how the profession formulated itself through careful boundary setting with social workers and doctors. In a bid to claim recognition as a 'profession', Dingwall (1977) illustrates how health visitors use atrocity stories to both claim equality with other health professionals, for example, doctors, and to demarcate their areas of competence from, for example, other nurses and social workers. He argues that, in order to achieve recognised status as a profession, it is necessary for groups to both lay claim to certain areas of work and to establish relationships of respect with groups who have recognised status as 'professions'. Stories, Dingwall (1977) argues, focus on health visitors demonstrating they are 'as good as' doctors, and 'better than' social workers (cited by Timmons and Tanner 2004:653). The findings presented in this chapter suggest that health visitors construct their expertise through a discourse which privileges health practices and suggests a tension between resistance and adoption of practices understood

historically to be more aligned to social work. This duplicity suggests a bid to retain areas of professional expertise which they are experiencing as being systematically eroded by other groups who are a more dominant/powerful force in setting policy agendas, for example, medicine, while, at the same time, to claim professional territory from professional groups, such as social workers, who, themselves, have experienced similar challenges to their professional status (Asquith, Clark et al. 2005).

The literature on professional boundary changes suggest that where changes between professional groups are occurring, a descriptive language of combat and protection is often used (Nancarrow and Borthwick 2005:912). The extent to which professional boundaries are in reality contested by different professional groups is uncertain (Timmons and Tanner 2004). Timmons and Tanner (2004:653) suggest that this blurring of boundaries may be due to demarcation becoming unclear within professional settings while to those outside of them little often appears to have changed. The language used by the health visitors when talking about their own professional boundaries tends to focus around the role being lost/eroded/eradicated, for example, 'I think it's an erosion of the service (HV15), we've been gnawed and gnawed' (HV14), and, 'I think it has been totally eradicated, just about' (HV3), with the frequent use of emotional/expressive terms in the construction of changes to the health visiting profession, such as, 'it's sad' (HV14), 'I feel saddened' (HV14), 'I think it is disappointing' (HV4); or of resistance 'not if I can flipping help it' (HV16). This perception, arguably, sits in line with the loss of power experienced by health visitors where they have experienced their knowledge, situated within subjugating discourses, to have been marginalised.

The health visitors' accounts suggest that their knowledge of children's development represent what Foucault (1988) described as subjugated knowledge. A small, but significant, literature has drawn on this idea in relation to nursing knowledge. They discuss the limiting nature of the discourses through which nursing knowledge is formulated and the implications of this for nurses themselves and their clients (Ryles 1999; Bradbury-Jones, Sambrook et al. 2008). Ceci (2003) highlights that subjugated knowledges are often also oppositional in nature. They exist on the margins and through their very presence they

challenge prevailing discourses. They suggest, Ceci (2003:128) argues, dominant knowledge(s) which are incomplete rather than a suggestion that they are wrong. Ceci (2003:128) suggests that the 'determined presence of nursing views of the world' despite a lack of recognition given to them points to this possibility. Likewise, the certainty and consistency with which the health visitors construct their knowledge and expertise as of value to the children and families with whom they work and our understandings of children's development as a society suggests that their knowledge may indeed occupy this space of subjugated knowledge, and, may have, if Ryles (1999:605) is to be believed, a critical role to play in the formation of new knowledge and progress.

Chapter 6: Health visiting practice

6.0 Introduction

This chapter considers how health visitors spoke about ‘family’ in their constructions of health visiting practice. It considers the relationships between family, place and health visiting, and the centrality of observational and relationships work with families. It considers how health visitors use their observations, including those gleaned through practices such as the weighing of babies, and ‘talk’ generated through their rapport and relationship work to construct ‘snapshots’, ‘pictures’ and ‘stories’ of families and their circumstances, albeit partial and gendered ones. It considers how health visitors’ professional judgement has been influenced by changes to their practice since Hall 4. It concludes by exploring how health visitors used their accounts of their relationships with other health professionals to illustrate the impact which Hall 4 had had on them as a profession and the children and families with whom they work. In the discussion, I explore why the health visiting profession has been challenged by current ideology around evidence-base and effectiveness discussed in Chapter 3.

6.1 The ‘family’ and health visiting work

The ‘family’ was spoken about by all the health visitors as a central focus of health visiting work. Health visitors did not, however, speak about or relate to all family members in the same way. Although the majority of health visitors spoke about all family members as relevant to their work, it was the mothers and babies who they spoke about as the focus of much of their work:

The baby is your client, number 1, the under 5s are our priority, as much a priority as the mother, and the mother’s mental health, and parenting, and what you observe as parenting relationships and bonding and techniques, etcetera, and her physical health as well. Then, what supports has she got, does she have a partner, does the partner live there, or is the partner supportive etcetera? So we are interested in the whole family, the whole family unit. (HV7)

I would say that our main clients would probably be the mother and the baby, but they operate within the family, so the whole family would be, you know, part of the world that they inhabit, if you like ... (HV6)

In the research interviews it was common for health visitors to initiate their responses to questions about their work with families by first using the term ‘parents’ and then to shift to the term ‘mothers’ as they embellished on the detail of their practice and started to draw on their actual experience of working with families through providing individual or broader examples from their work:

... you are looking at every time ... what the parental input is, how the parenting is going, how the child is presenting, both socially and emotionally and physically, so all these things you are doing every time, and how the mother is coping. ... obviously, if the mother is not coping, and she is the lynchpin to how the child is then going to present. (HV4)

It was the mother who they spoke about interacting with the most and subsequently developing a relationship with. Although the central relationship was between the health visitor and the mother, including ensuring her health and welfare, its end purpose was to ensure the health and welfare of the baby. This brought the concept of coping, and the mother’s coping in particular, centre stage. The terms health visitors used included: ‘is she coping well?’ (HV1), ‘a professional mum, who likes to be coping’ (HV 4) and ‘seeing how the mums in the families were coping’ (HV6). Judgements about coping, and more widely in relation to mothers’ mental health, were often spoken about as an indicator of wider family functioning and as directly indicative of how well a baby was being cared for:

I review her mental health again ... if the mother is not functioning it impacts on health and development in a huge way. (HV1)

There was a complexity to health visitors’ relationships with mothers which went beyond their greater presence and interaction with health visitors. There was a gendered aspect to the relationships where health visitors felt a greater emotional connection with mothers:

... because of the difference between men and women emotionally, probably being a female health visitor, with mothers, you tend to find that you do have a rapport and an understanding whereas the men sometimes can be coming from a different angle, emotionally. (HV4)

I suppose sharing emotional vulnerability. I didn’t appreciate until I was a mum how emotional you get, how you can love them and hate them in one breath. Just sharing that with someone who is at the end of their tether ... (HV8)

A few of the health visitors in their accounts suggested that they felt that there was also a moral obligation to recognize the mother's greater caring responsibilities in families as the health visiting service resources were limited and could not always extend to all family members.

The majority of health visitors also spoke about families in relation to their generational connections. Their accounts of grandparents were again gendered, with their focus on 'grannies' and 'grandmothers', and in relation to the health and welfare of the baby, this time through the grandmother's relationship with the mother and immediate family of the baby:

... whoever was in the house, really, if granny is there, then she has got to be [included], but the focus is on the mother and the child. (HV16)

I do try and work very hard, because the same as grandparents, if the grandmother says something about cold tea ... for a sticky eye, then I am not going to discount it. I'll say, yes, that is something that has been used with great effect, and saline is also [laughs], you know, and even breast milk nowadays. ... there is absolutely no good setting up barriers with any member of the family. Because that just, that just can cause problems later down the line. (HV4)

The presence of a grandmother in families, particularly for young mothers, was also related to resilience and social inclusion by some of the health visitors:

... even very young mums ... some of them – a lot of 14, 15, 16-year-olds, you find depending on the circumstances and the wee girls involved, you can back off then, you know, but it's just making sure that everything's okay and their granny, or the baby's granny is there. (HV14)

The majority of health visitors differentiated between first-time mothers, often referred to as 'new mums' and mothers with more than one child. 'New mums' were, in the most part, identified as those in need of most input from health visitors.

Fathers or dads were spoken about differently in the health visitors' accounts. Health visitors occasionally related to fathers as primary parent. This, however, health visitors suggested, was still rare. It was spoken about by health visitors mainly in circumstances

where the mother was absent or when mothers were working outside of the home and fathers had left employment to care for children on a full-time basis. The health visitors spoke predominantly about fathers as partners of the mothers whose relationship was the key element to the health and well-being of children in the family. They were often also spoken about as 'invisible' to an extent, through their absence from the home when health visitors visited:

... if the dad is around, I always try and encourage them, and say, "Look, you have got to remember, we are family health visitors, we are here for you as well. If you have got worries about the baby, or if you have got worries about your wife, you know, the phone number is there for both of you, not just for mums." And I think it is important that they feel, not many of them do it, but you know, to at least make that link. (HV1)

I will maybe see them when they are on holiday or something, but as I said, we have only got 6 months to make the, and dad might not have holidays for 6 months. ... officially we work 8.30 to 5, so it is the normal working day, so unless they work shift work ... I mean, we sometimes meet them in the early days, because a lot of them will take paternity leave ... (HV1)

I think often at the beginning ... occasionally there will be a father there, interested, but because they are off working, they are not, you know, in some families they are not visible ... (HV15)

On some occasions it was the absence of fathers that caused the health visitors to become aware of the impacts of this on children's health and well-being, for example, when fathers serving in the army or other forms of employment were away for home for prolonged periods or where children had moved schools several times in a short period.

Where men were spoken about solely as partners (in circumstances when they were not the biological fathers) the absence or presence of a partner was described in different ways as both potentially supportive and unsupportive. Health Visitor 8, for example, talked about an 'unsupportive partner' and Health Visitor 1 referred to 'looking at other supports ... whether there is a partner present'. At times, the presence of a partner was viewed as potentially harmful depending on their relationship with the mother of the baby:

And quite often we do home visits just to assess the situation, to see if there is support the mother needs, or the child could be at risk because of the partner, and we have to suss that situation out. (HV11)

Fathers' marginalization in health visiting work was not just to do with their absence from the home and interactions with health visitors. Health visitors also drew on other explanations identifying that their perception was that the health care of children was often viewed to be 'women's work' or the 'women's domain' within families. In these ways fathers were often absent in accounts as service users and differentiated from women in terms of their role and impact on their children's health and welfare:

I would ... address both of them together, but there is still often this kind of sex division where the mother is mother and the father is just kind of there. (HV15)

... some dads do come along to the clinic ... but I still find, even if partners are there, they would sometimes take a back seat when I am going through the parent-held record, and sometimes I have got to almost physically draw them in to show them, to say, you can look at this as well. It is almost like they still think it is a bit women's domain. (HV9)

The health visitors' accounts of family in relation to their work suggest a gendered approach to the family which is both driven by and perpetuates wider societal trends and shapes their relationships with children and their families.

6.2 The relationship between family, place (generally homes) and children's health and well-being

In the previous section I considered how health visitors spoke about family as a collective of people related biologically and/or through (strong and weak) relationships with one another. All of the health visitors described how these relationships became understood through seeing and interacting with families. This contact predominantly took place in clinics and homes with each place generating different forms of knowing about, and making relationship ties with families. All of the health visitors expressed a preference for meeting with families in their homes over clinics, particularly during their first point of contact,

including the notification visit²¹, after a baby was born: ‘... the [notification] visit is usually about an hour, a good hour in the house’ (HV1). Homes were spoken about in two ways: they were an object of scrutiny; and, they were a site of health visiting practice. These were not distinct from one another in that health visitors did not go to homes with the primary objective of scrutinizing it, and equally did not engage in health visiting work with family members in a sanitized way where the home did not feature in their judgements:

I would offer to do a home visit. And usually if people are a little bit resistant, then, I am always slightly concerned, I wonder why they don’t want a home visit, because hopefully it is not a threatening thing, it is just I’m the local health visitor ... (HV4)

... if they are what I would deem to be possibly a vulnerable family, I would really try and get in and see what the home conditions are like. Because it gives you a much clearer idea of what the children are experiencing. (HV4)

In this sense, although all the health visitors spoke about the home as a place of health visiting practice, their interactions (or lack of them), in and through the home provided became part of the nuanced knowledge which health visitors possessed about individual families. Health visitors referred to ‘knocking on the door’, ‘being in and out of the door’ and about arriving at their door for an appointment they had arranged and the family not being in the home. In this way, the very presence or absence of a family from their given home address could act to influence how an individual family and their circumstances were understood in the context of health visiting practice. ‘Keeping the doors open’ was also used metaphorically by a few of the health visitors and again reflected a wider discourse around children’s health and well-being in relation to the monitoring and surveillance of parents as an aspect of contemporary child protection agendas:

If it is a situation where you have got a concern about a child and the relationship between a parent and a child ... you have really got to keep the doors open as far as you can ... (HV7)

... for a transfer in [family new to the area]who appears at that first visit to have no particular health issues or social issues, then I would expect that might be a complete one-off. I wouldn’t expect to see them again unless there were ongoing issues of any sort, but I always leave the door open. (HV4)

²¹ The notification visit is a statutory visit carried out with all families by health visitors 11-14 days after a baby is born.

The home provided a rich source of knowing for health visitors. Families and the environments in which they lived were constructed in different and dichotomous ways in health visitors' accounts. Broadly speaking, the 'vulnerable family' was constructed by the majority of health visitors through reference to drug use, dirt, chaos and a lack of organisation. Many of the health visitors also worked through their accounts to resist this association, and expressed that this was not the only form of vulnerability by contrasting it with the professional mothers, also deemed potentially vulnerable, who were constructed as organised and coped well in the workplace before and during her pregnancy and then became isolated after her baby was born. Health visitors used phrases such as a 'good home environment', seeing 'what the home conditions are like', 'are they warm, dry, clean, are they kept in a safe place?', 'what is the home safety looking like?', and 'you go into the house and this is a mess', and referred to the presence of toys, safety equipment, and cleanliness as relevant observations:

... it lets you look at their home circumstances as well and things that have changed, like if they are going to start cooking for a child and what sort of things do they eat? And teething, you know, you maybe only get to see the bottles and how inappropriate they are. Yeah, I try to home visit. (HV10)

... is there an extra lodger lying on a bare naked bed in the kitchen and a hot plate on, and a child sitting on the cooker next to the hot plate, or you know, is there a pair of drug scales in the house? (HV7)

In this way, they constructed the home as an object of scrutiny through which children's health and welfare were monitored and judged.

The home was not viewed in isolation but in the context of the communities in which families lived. Health visitors often spoke about disarray within the home as the responsibility of the family, whereas structural damage to homes inside and out was more often attributed to external factors over which the family had less control, as these two contrasting extracts suggest:

... if it's excessively dirty ... I've been in homes that I've gone to that you can't see the colour of the carpet; so it's not like I'm being judgmental, but if it's clear that you are sticking to the carpet, you can't see the colour of it, there's a pattern on it,

but, you know, it's just absolute filth; then just dirty dishes or unhygienic bottles or excessive amounts of furniture. (HV15)

I don't know how some of them manage, when they have got, one or two or three children and they are four flights up and the stairs are filthy with human and animal excrement and they are chundering toddlers up and prams up and it is going through that, that must be really difficult for them. ... the housing maintenance is appalling, you know, it takes nothing, if you put a buggy against the wall, you get a big hole in it, they are like corrugated cardboard, the walls are literally paper thin. ... they ask for repairs and it doesn't happen, and it is dangerous as well for the children. ... and they have to cope with that. (HV9)

Although wider environments in which children lived were not made the responsibility of families through health visiting practice, the health visitors' accounts suggest that they formed part of how the family was known by the health visitor.

It was again the home environment that provided health visitors' observations of the interactions between family members with context and detail which was not available to them in other settings such as health clinics. Health visitors spoke about homes as places where they could observe how parents related to their children, each other, and other family members living in the home by seeing them in their everyday environment. They used terms such as 'looking', and 'watching' how the parents are 'handling', 'helping' and 'engaging' with their children to describe the observations they made of relationships within the family:

... it is an automatic thing where you are just looking at the relationship. How the mother handles the baby. The bonding process. Are they handling the baby normally or like a sack of potatoes, you know, what does it look like, the rapport going on, and later on, you are watching is the baby engaging with the mother, you know, as they get that wee bit older. (HV7)

... [watching] how the parents are helping the child ... are they getting the opportunity to crawl along the floor or have they got appropriate toys? (HV15)

The health visitors spoke about the home as providing opportunities for observation and at the same time constructed this in the context of the home being a preferable site for health visiting practice due to the convenience it offered for new mothers who could relax and attend to their baby at their own pace. Health visitors spoke about it as a place where

mothers could ‘be themselves’ and tend to their babies, particularly in the early days. This seemingly altruistic gesture, however, also allowed health visitors opportunities for close observation of mothers and their mothering practices not available in other settings:

You know, if they want to breastfeed, or change the baby, they have got everything there. And it is also good for us to see how they operate in their own surroundings. And hopefully what other supports are around for them as well. I feel you get a far better impression of how people are coping when you actually see them at home. And they are far more likely to tell you things than they are in a busy clinic. You often get more information. (HV6)

Health visitors’ observations of the family’s daily routines included what families ate, how they prepared food, bedtime routines, children’s ‘picky’ eating habits, and how bottles were prepared. The health visitors suggested that it was through their knowledge of the practices within the home that they were able to mark out similarities and differences with the knowledge they had gained about a family from interactions and talking with family members. A few health visitors also highlighted that practicing in this setting provided them with a collective awareness of shared practices between mothers living in the same communities, as HV9 does here through her reference to ‘it is not the first time’, ‘what has happened in the past’ and ‘it is still going on’:

Assessing the, well, the parenting capacity, and their skills, and basically, right down to see if they can make up bottles properly. It is not the first time where I’ve asked them how many ounces they have in a bottle, and they might say, usually 3 ounces, but it might be 4, and well, to cut a long story short, what has happened in the past and it is still going on, is they will put 10 scoops in a jug and 10 ounces of water, stir it up and pour, 3 ounces, 3 ounces, and what is left in the jug. So, it is really getting into, do they read what’s on the tin, and showing them how to make up a bottle. (HV9)

The health visitors’ accounts suggest that the observational and relationship work they do with families, and the nuanced nature of it, both shapes and is shaped by their professional judgment, which in turn they have experienced differently with changes to their practice since the implementation of Hall 4.

6.3 Weighing babies as a health visiting practice

All the health visitors spoke about observations which they made of both the baby and the mother’s health and welfare through physical examination. These activities primarily took

place in the home as part of the notification visit and home visits in the initial weeks after a child was born with some aspects being continued outside of the home in clinics and other community settings:

... looking at the child's physical health ... were they born on term, or were they born pre-term, have they got jaundice, are they alert, have they got good muscle tone, are they feeding well, what's their skin like, are they hydrated, what feed going in, what is the method of feeding, is it working? What's their elimination at the other end? All that basic bread and butter stuff. (HV7)

... the baby is putting on weight and the mum is sleeping and the baby is sleeping four-hourly and there is no pain involved, the woman's perineum is fine, it is intact. .. then you go into somebody else's house who has had a caesarean section, she has got mental health problems, and the baby is jittery ... (HV1)

Weighing the baby and monitoring its growth and development through charting this over the first weeks and months of the baby's life was one aspect which provided data for health visitors and mothers. Health visitors noted a shift in this practice which coincided with Hall 4 where they weighed babies less consistently and less often than before. As well as monitoring the weight of newborn babies, health visitors described weighing the baby as a way of ensuring contact with a family, as well as encouraging interaction while meeting with parents:

I recommend perhaps a weekly weight check for the first 6 weeks, just to make sure the baby is doing okay, but it is also a means of contact and getting to know the parent as well (HV4)

.. show them the centile charts, to show them the weight and length of the baby. (HV9)

In this way, this gathering of information was as described by health visitors as an aspect of health visiting practice through which they engaged with families and planned future intervention. Health visitors' accounts suggested a shift in focus from weighing babies as a routine practice to one driven by concern and/or demand in line with broader developments shaping their practice (i.e. around the relationships between universalism and targeting, normality and risk and public health to child protection):

In times gone past I probably would have always taken the scales out and asked if the parents would like their baby weighed. I don't necessarily do that now because

you know, I think in times gone past I felt that it was being handed over to me, and this was my first baseline assessment. But, you know, it is a change in practice and attitude and I have to go along with that really, ... Obviously I will weigh the baby if there has been express concern, express demand. (HV2)

This example is illustrative of a wider aspect of how the health visitors spoke about changes they were experiencing to their practice. These had implications for the way in which they worked with families in relation to diminished opportunities for home visiting and for the development and maintenance of relationships with families. The health visitors' accounts suggest that their embodied knowledge of children and mothers was a central aspect of how they judged whether a mother was adapting and responding to her changed circumstances and whether the child's health and welfare were being ensured.

6.4 'Talking' as a central aspect of health visiting practice

As well as the observations which health visitors made in homes, they spoke about the opportunities it provided for interacting with family members, which in turn they identified as central to the development of relationships with family members, primarily mothers. All the health visitors spoke about the importance of what they could glean from mothers and other family members about their circumstances and often referred to 'the story' or 'their story' in accounts and giving the opportunity to 'tell their story' and starting to elicit an 'account' of a family and their circumstances. Health visitors spoke about this as a process to which they returned either through future home visits and/or meetings in clinics or other settings:

... sometimes you have to shove your agenda on the back burner and do it in the next visit because if they are bombarding you with questions ... and then you know next time round you can get information. (HV4)

... it's the health needs, emotional needs, social needs. So it's getting a good picture of the family and, again, it's just to look at if there's any additional supports are going to be needed. They can be quite lengthy visits. It usually takes about an hour to do one. And, again, it's kind of assessing, having a look at the baby, seeing how they're doing. (HV12)

Health visitors spoke about a range of techniques aimed at initiating and developing relationships with their clients. One such technique spoken about by the majority of health visitors was rapport:

... building up a good rapport with them, and a rapport that they know that they can trust you, and that you are a health professional, and you have got the background and the training, to back that up ... (HV11)

... just to try and establish some sort of rapport or relationship. (HV4)

Almost half of the health visitors spoke about 'rapport' directly, while in the majority of the remaining accounts they spoke about it indirectly, through the use of terms such as using 'banter' or describing ways that they were in their interactions with parents such as 'gentle', 'empathetic', and as being 'able to listen and able to be quiet'. In interviews health visitors used terms which suggested their approach was a process which, once initiated, developed over time and with contact with families such as 'building up', 'establishing' and 'getting to know'. This was again gendered where rapport was a technique which health visitors described as using in talk with mothers over any other member of the family:

I just feel it is quite important those first few weeks to try and get a rapport going with the mums. (HV3)

And I find that by the time they are 6-8 weeks, I have a fairly good rapport with the mum. And I would say, up until the child is a year old, I think she would contact me. (HV1)

Just as rapport was essentially a technique used in talk with mothers, it was mothers with whom health visitors talked about forming a relationship:

And it is usually in those early days that you make the relationship with the mother. Because if you don't do it then, then you don't tend to get that same relationship. (HV6)

All the health visitors, in different ways, spoke about rapport as helping relationships to develop. Health Visitor 7, for example, did this by noting that when it is absent relationships with families are often not established. She and the majority of other health

visitors spoke about the decision by some families not to have contact with them as their choice with the exception of when they had a concern about a child's welfare:

Very occasionally ... you get somebody that just doesn't want to work with you. They just want to do their own thing and they really don't actually want you there. ... And sometimes you think, well, maybe they could do with talking to you, but they just won't. You don't know what the barriers are, sometimes you do know what the barriers are, but you can't work with someone, that is fine, that is entirely their choice ... And as long as we have made them aware of services that are available then there is nothing that we can do to force that issue. It is different if it is a situation where you have a concern about a child ... (HV7)

All of the health visitors spoke about these concerns about children's welfare as a central aspect of their practice. Health visitors spoke about adopting techniques to ensure that they maintained access to families, which became particularly relevant when they did have concerns:

I think for us it's being open and honest with clients, and, you know, particularly working with vulnerable families. ... I think really you have to gain respect from them, and it's them feeling comfortable with you, able to talk to you about anything that's bothering them, and, again, contacting you if they have any concerns and feeling that they're able to do that, that you're approachable. I always say that, "If you've ever got any concerns just give us a phone." (HV1)

* CK...What is your experience of that, you know you want to be honest, but how that plays out in practice really?

*HV3: I think sometimes you need to fudge round it. That sounds awful, but you don't come out directly and say something, but say to them, "Why do you think I have concerns about the state of the house?", or "Why do you think I worry if the child is not at school on time?", get them to think of why I might be concerned about something if you can ... particularly with some families because you think if I say what I think I am either going to get booted out this door, or not back in again. So, it sometimes takes a while to really say what you want to say, and you almost want to drip-feed your thoughts. (HV3)

All of the health visitors spoke about their relationship with families as central to their practice. This theme was illustrated in accounts when health visitors spoke about 'building up relationships', 'cracking relationships' (HV8) and relationships being 'absolutely crucial to the whole set-up of health visiting' (HV4). All of the health visitors talked of strategies, the use of rapport (see above) being one, which they used to develop relationships with families. In a bid to develop and maintain relationships, all the health visitors spoke about

aiming to be supportive in their approach with families. They used terms to suggest this, such as that they were, 'flexible', 'open', 'friendly', 'helpful', and 'caring':

... it is very much saying, "This is the resource, this is the service ... and please don't wait for me to come to the door. Pick up the phone. And do not worry about being a trouble ..." (HV2)

I am never that far away, if they need to see me that day I will be around. (HV9)

All of the health visitors, in different ways, suggested that the relationship was defined by a particular set of understandings about health visiting practice. Some of the health visitors spoke of the universality of health visiting as a central aspect of their ability to develop relationships with all families:

... whereas before the health visitor was just there and she just turned up and ... you would go from one type of house into the next type of house and you'd just see everybody and that's been lost. (HV14)

I think, well, generally, because you know, everybody has heard of health visitors, you know, it's non-threatening, it's non-statutory, ... and that is a good place, or a better place to work with families from ... people are people and some people are easier to work with than others, but generally because of the universality of health visiting people are happy to work with you. (HV16)

Other health visitors constructed the relationship as a central aspect of health visiting practice which was both enabled by contact and at the same time limited in its reach when opportunities for contact were compromised. Health visitors commonly drew on Hall 4, directly and indirectly, and the changes to their practice they had experienced since, when making this point:

... just to try and establish some sort of rapport or relationship, because we are not going to see them in the same way that we used to, because of the implementation of Hall. So we have to really, that first bit has to be quite concentrated to try and establish how they are getting on, how they are managing as a parent, as a new parent perhaps, or as a second- or third-time parent, and if there are any other stresses and strains in the family that might become evident in that short period of time. (HV4)

I think they are terrified that you won't know who they are because their child is now two-and-a-half or three, and you don't ever see them. So, I think it is a shame

for them, from the mums' point of view, because they sometimes don't know who to contact. They are worried that maybe I am not the right person to contact now, because maybe I haven't seen the child for a long time. (HV3)

While health visitors spoke about relationships as being central to health visiting practice and their knowledge of the families with whom they work, this had inherent tensions. In speaking about these relationships, health visitors did not necessarily speak straightforwardly about these tensions but rather moved within their accounts between positions which suggested that relationships were supportive and/or about enabling surveillance:

*CK: ...What is your ideal relationship ... with parents?

*HV7: I think one where the parent can be comfortable that we are approachable that we are not the health police and that we are around for support and back-up if they want it and there is somebody to bounce ideas off. We are somebody that steers them through problems if problems arise. (HV7)

She continues later in her account:

... it is their life and you are in their house and yes, you are policing the situation really, but you are being much more open about it than in the old days. (HV7)

This expressed ambivalence is illustrative of a tension evident in the health visitors' accounts where they present themselves as being supportive to all family members, while it is the child's health and welfare that is their primary concern. This tension, to an extent, the health visitors suggested could be ameliorated through the relationships which they developed with families. However, these relationships are dependant on opportunities for observation and interaction with families which, their accounts suggest, have diminished.

6.5 From the home to the clinic

Although all the health visitors spoke about the importance of the home as a site for health visiting practice and opportunity for observation and interaction, they all highlighted that for the majority of families interaction after the first weeks after their baby was born was (increasingly) outside of the home in baby clinics, community groups, immunisation clinics, at weaning talks, and breastfeeding groups. Health visitors constructed these settings as

different from the home. They spoke about them as opportunities for parents to meet with one another:

... the [group] was to empower the parent, and to get them to socialise. (HV1)

... they quite like coming to the baby clinic and having a wee chat. (HV14)

While health visitors spoke about these events as useful in this sense, they constructed them as providing fewer opportunities for them to develop their relationships with families and, as a consequence, their knowledge of families. In this way, they suggested that these opportunities for constructing their knowledge about families were less informative to them in terms of identifying any concerns they might judge there to be in relation to a child's welfare:

I haven't been doing [antenatal visits], I am going to start to do it soon, I had to stop it because of short staffing, and we had to prioritise, and that wasn't a priority, and I was depending on when I did the parent craft catching up with mothers there that were pregnant from my practice, which really isn't ideal, because you want to go to the home and see them, and build up a rapport and give them time to chat to you on a one to one basis ... (HV11)

... clinics ... they are seeing a different health professional and that worries me because I am, I have been at this long enough to have seen it go full circle and it worries me that they may have mental health issues, the mother, it worries me that there might be a child protection issue that you are missing, it worries me that the health visitor seeing this person can't know the background. (HV7)

As well as providing fewer opportunities for observations of and interactions with families, health visitors expressed a concern that the clinic encouraged new parents to present themselves in a way which may inhibit them from gaining the same insights into what they were experiencing as they might if they were to visit them in their homes:

We do the post-natal depression about eight, nine weeks ... So that's another home contact so you can get to make sure that your first couple of assessments were right so you can keep – and be doing them twice so it's two home visits to make sure everything is ticking over, 'cause the downside of them coming to the baby clinic is they put make-up on and get themselves dolled up and everything's hunky-dory. Unless they get you on your own, you know, then they might be more honest. But in the baby clinic they tend to just stick together and they've got their baby. (HV14)

In this way, the location of health visiting practice, although often constructed through being convenient, was central to both the relationship between health visitors and the families with whom they worked and to their knowledge of these families and their circumstances.

6.6 Health visiting practice and making judgements

The health visitors spoke about how making sense of their observations and interactions with families was a central aspect of their practice which was shaped by their professional experience:

... it's just a whole layer upon layer of assessment that you've learned over years of work. (HV15)

... and having a clinical judgement I am sure that handing over forms and having a tick box, we can all come off the richter scale, but we can be fine, and other times you are not, you can not have such a high score, so at any, the key factor is professional experience and clinical judgement aided by the tool. (HV2)

The importance of their professional judgement as health visitors was highlighted in their accounts when they spoke about 'knowing when to worry'. Other similar phrases used by health visitors which suggested a knowing based on their experience of working with families were being able to identify 'worrying cases' and in relation to when they felt 'you should be concerned or not concerned'. All the health visitors suggested in their accounts that skills of professional judgement were necessary and enabled them to make decisions based on nuances of knowing as to when and how it is appropriate to intervene in family life, and that it was their role, as health visitors, to do this:

I think knowledge of the family you know who you are visiting and I think a first assessment can be totally different to a second assessment, you know your first visit to somebody you could be concerned or not concerned and the second could ring alarm bells, and I think you have got to make sure you don't go by your first assessment. (HV3)

Health visitors constructed their professional judgement in relation to a range of processes which were enabled by their experience as health visitors. One aspect of this was their intuition which was based on and guided by their knowledge and experience as health visitors:

... a lot of it is subliminal. I suppose you get a feel for it, and I suppose ultimately as well, you know ... what was your gut feeling about that? Did you come out feeling that you got the whole story, or did you come out thinking, that doesn't make a lot of sense to me? (HV10)

... every visit I do to a family I do as part of an overall assessment. ... of where they are at, so from knocking on the door, to getting in or not, it starts there, you know, observation of the physical surroundings, observation of the mother, you know, just, the very general assessment from what you see around you. I'd want to have a physical examination of the child if possible but if mum doesn't want that, that is fine. The physical weighing of the child, if mum wants that, that is fine. I will observe mum and child interactions, while trying to get mum to talk about whatever she is finding easy, difficult, good, bad, with the baby, with her life, with her flat, with her money, with her family, you know, and that sounds like you would be there all day, but it is not really like that because once you have met somebody a few times, you know where the difficulties lie ... (HV16)

Health visitors also spoke about the importance of their professional judgement in relation to written/computerised records based on their judgements of families. There was evidence of a tension in this where meeting the needs of one family member could have consequences for another. Health visitors spoke about being aware of this and of the care which they took, for example, through thoughtful wording of reports, to try to minimise stigma and inadvertent harm:

... how happy was a health visitor writing down family history of depression on that child's form? ... I think before it was something that we would often have in our heads, but it wasn't actually officially on the form ... the same with, if there was use of drugs in the house, you wouldn't have previously have written that as blatantly on the child's form, that the parent was then seeing and was then shared with a computer, and it wouldn't come back to you on a computerized form. ... I think of many professional women who I have dealt with who have maybe had mental health issues, they have had postnatal depression, or even a more long-lasting mental health illness in the past, and they would not want that to be on the child's record. You know, definitely not, and I can think of at least one where I've lightened it a wee bit ... (HV7)

... when the computer printed out "drug-abusing family". Well I don't want that going on any form for a mother. ... you might put "social issues". (HV4)

Health visitors commonly used photographic metaphors in their accounts to describe these processes of accumulating and assimilating information. These included, 'getting a

snapshot', 'the whole picture', 'getting a good picture of the family', 'looking at the much wider picture', 'you have kind of built up a picture', 'a fuller picture' and 'a clear, a more clear picture'. They often used these to illustrate that their knowledge of families was only every partial, based on the observations and interactions available to them:

I think it is getting a global picture and very much a raw picture from what the family presents you with. But having said that I am also very well aware that you don't always get what is really there, you know, you might be presented with a certain set of circumstances or a certain bit of information and actually there is a lot more going on than you really know. (HV5)

... you don't know what is going on behind closed doors, you never do, and it is people's private lives, but all you are doing is getting a snapshot each time, and trying to build up a picture, but these snapshots are difficult ... now [emphasises] because we are not really privy to do it. We are not able to do it. (HV4)

Through their talk about their knowledge of families always being partial, health visitors highlighted the limits of their role. At the same time, however, they spoke about their knowing of families as being directed by an awareness of their role in enabling and protecting children's health and welfare as this extract, again from Health Visitor 5 building on the previous one above, illustrates:

I think that is very pertinent, I mean in respect of acting on things that you see and hear, you know, we know that we have to look out for certain things that are going to be dangerous and damaging to children and so we can act appropriately and promptly, but if we don't see and we don't hear, we can only act on what we know. (HV5)

The health visitors suggested that their ability to judge and the judgements which they made of families were influenced by a number of factors. These included what health visitors spoke about as being central aspects of their profession (discussed in Chapter 5) such as their experience gained through working with families over time and codified knowledge gained through their own educational experiences both in training to be a health visitor and as a health visitor. At the same time, health visitors spoke about their interactions with families being influenced by other factors such the introduction of assessment tools into their practice. Health visitors spoke about these tools as both assisting and hindering their professional judgment. Over and above this however, they

spoke about them as offering a professional protection in a climate they were experiencing as increasingly less responsive to the worth of their professional judgement and as promoting a discourse around child welfare/protection. This discourse did not necessarily fit with their overall experience of health visiting as an essentially supportive profession, albeit, with nuances and complexities based on at times, the competing needs of different family members. These extracts from Health Visitor 12 and 3 provide some insight into these complexities:

I think we do need to have quite robust assessment tools to use. We shouldn't have to, but it's to justify what we're doing and how we've come to the decision that this family are going on such and such a level of care, and I think we do have to have the evidence to justify that. (HV12)

... because at present you feel kind of, I suppose quite vulnerable that you are supposed to decide what these families are and there is nothing written down, so if we have this as a written piece of work, to say, right, at this time, this family were fine, I suppose if in 6 months' time, or a year's time somebody says, "What has happened?", I can say, "Well, actually, at that time they were fine and I put them onto Core." So I think it is kind of, it sounds awful, but a kind of safety net for you as a practitioner, I think, in this day and age. (HV3)

At the same time health visitors spoke about resisting using assessment tools fully by asking some of the questions, distancing themselves from the tools by explaining that they were required to use them by others (e.g. managers, or policy directives), using it with only a few within their caseload, or not at all (most often after consultation with their manager). Many of the health visitors also expressed concern that the tools inhibited the use of the full range of professional expertise within their teams:

... there is a lot of it that I feel we don't have a right to ask, and I know it is a guidance about some of the things, and like, does the child sleep in clean bedding and things, we don't have a right to walk into someone's bedroom, we don't have a right to be in their house, but as health visitors we are one of the few people who have the ability to knock on someone's door ... they are kind of half expecting to see the health visitor, so we are allowed over the front door, but we can't say, well, "Can I just check your bedrooms while we are in?" That is not on. And there are other bits, you know, "Is your child happy with their mother's care?", and if a health visitor asked me that, I would be showing them the door. It is very intrusive. (HV9)

*CK: And how do you find the parents that you are working with, how do they receive the [assessment tool]?

*HV6: I'm not at all certain that they actually understand that it is part of the bigger child protection picture, which it is. ... I just say I am looking at the wider picture of child protection and I show them the forms that we use, and say, these are the things that we are being asked to make comments on ... But I am not really sure that they really understand what that is about.

*CK: Yes, it would be interesting to know, I suppose, what child protection means to people who are not working with it.

*HV6: And I suppose that is the bit that I don't do, I don't say, "Do you know what child protection is?" because I don't really want to go there, yeah, at that particular point in time, yeah. (HV6)

... they want us to work in mixed teams and then they add things in to make it difficult for you to use your team as you see appropriate ... you should be able to judge who would be appropriate to go and visit that family. ... they have to allow you to use your team as you see appropriate ... (HV14)

The majority of the health visitors spoke about how the demands on them as professionals, where they had less contact with families than they had experienced previously, had implications for both them as professionals and for the families with whom they work. They described a service which was less responsive, where they knew families less well and which was now increasingly focused on families who were deemed more vulnerable as this extract from Health Visitor 1 and the filing cabinet drawer analogy of Health Visitor 3 below suggests:

... It used to be very responsive, now it is not responsive at all. Because once you get to 6 months, everything is alright, you put them on core and then after that it just depends if someone says to you there is a problem. (HV1)

I think because I don't know my case load as well as I should because I don't have the regular contact, as I say to you, I assume everybody in these bottom three drawers is fine [of filing cabinet] or the bottom two drawers, because you are concentrating on the top one and everyone you are just hoping is okay, so, I feel you are missing out on that. (HV3)

In this way, health visitors spoke about professional judgement as being both required as a health visitor working with children and families and acquired through their experience of working as a health visitor. Through their accounts (discussed here and in Chapter 5), they

articulate their experiences of policy/practice contexts where they feel that these opportunities have been diminished, with implications, they suggest, for themselves as professionals and for the families with whom they work.

6.7 Relationships with other professionals

Health visitors spoke about a number of other professionals, for example, midwives, social workers, GPs and speech and language therapists. They suggested that these interactions had several functions which varied across groups and which they had experienced as shifting in their focus. Through health visitors' descriptions of their interactions with other professionals they record a subtle, yet noticeable, shift in the discourses shaping decisions about which families become known to them. They suggest a shift experienced by them towards knowing only families who have been deemed vulnerable. Deemed vulnerable, that is, in their judgement as health visitors in conjunction with that of the other professionals with whom they interact. The health visitors' accounts of both their relationships with different health professionals and how they believe these to have changed illustrate this. Increasingly, they suggest, their interactions with midwives, in the absence of families themselves, enable them to make decisions about which families they will make contact with in the antenatal period, albeit, their preference, their accounts suggest, is to make contact with all families:

... that's a decision that's made jointly with midwives, so what we do is we sit down with midwives on a periodic basis and we'd get all the antenatal mothers on the practice caseload and identify those who may have additional needs or may be complex ... the antenatal mother who identifies with additional needs or having very complex needs obviously we would arrange a visit, to make an assessment. (HV13)

Just as they spoke about their interactions with midwives as informing their decisions about which families to contact, they also described their interactions with other professional groups as changed and as providing different functions. For example, they spoke about their interactions with GPs in terms of reporting on families deemed vulnerable over a previous engagement around child development screening, and their interactions with social workers as increased and as in line with social work practice, by implication practice which is more focused on some 'vulnerable' families:

... we have monthly GP meetings, well, 6-weekly meetings now, where we are sharing, I'm discussing the family in needs records with them, not all of them, because there is too many, but just the ones who are top, who are boiling at the time of the meeting, who there are specific issues for. (HV4)

There is a lot of our work since Hall has been implemented has increased with much more social work orientated ... (HV4)

The majority of the health visitors referred to the referrals they made to speech and language therapists. How the health visitors spoke about their relationships with speech and language therapists again suggests a shift towards health visiting practice shaped by discourses privileging and shaped by notions of vulnerability. The majority spoke about their referrals as having decreased, which, those who developed this aspect of their accounts suggested, is due to shifting health visiting practice rather than through changes in the difficulties children are experiencing when acquiring speech and language skills:

... what would be really interesting as well would be looking at, and I'm sure someone will look at, the speech therapy and referrals to speech therapists, have they gone down, have they gone up, you know, who is referring now, because I don't feel it is me. I am not referring in the main as much to some of my colleagues.

*CK: Right, so you have noticed?

*HV5: I've noticed that it has gone down, yes. I can only think it is because I don't see the children not because the problems have gone away. (HV5)

Underpinning the health visitors' accounts of the changing nature of their relationships with other professionals is a suggestion that this shift has been influenced by the changing nature of health visiting practice. There is a sense of reluctance and regret in how the health visitors describe these changing relationships, suggesting that the impact has been experienced by them personally and professionally, as discussed in Chapter 5, and in terms of the changes it has brought to how they now work with families with young children.

6.8 Discussion

The gendered nature of health visiting practice has been documented in the literature. This has focused on: how fathers are both absent from and absented by health visiting practice (Edwards 1998); the shift in discourse from mothering to parenting in public policy which belies the gendered nature of the family (McKie, Bowlby et al. 2004; Hollway 2006); and

within the literature on domestic violence the need to understand the complex narratives of women's experience of mothering to inform health visiting and social work practices (Peckover 2002b; Davies and Krane 2006). The findings spoken about in this chapter also suggest a health visiting practice which is informed by and acts to perpetuate a gendered approach to the family. The findings go further, however, to suggest a shift towards health visiting practice which is increasingly shaped by and which focuses on vulnerability. The health visitors' accounts of vulnerability in the context of their practice will be developed and discussed further in Chapter 8.

The dominance in the findings of health visitors' focus on their professional judgement brings to the fore a number of aspects for discussion. Peckover (2002a:373) argues that within health visiting practice pastoral power is, 'much more than simply finding out; it is a process that involves "knowing and becoming known"'. This process, which the findings of this study also suggest is pivotal to health visiting practice, is a central aspect Peckover (2002a:373) suggests, of how health visiting works in a regulatory manner whereby, 'mothers become the subject and object of the health visiting gaze' (Peckover 2002a:373). In addition, however, this study suggests a shift in how the subject of the health visiting gaze is constituted. Increasingly, the health visitors' accounts suggest a shift towards the vulnerable subject being the focus of the health visiting gaze.

Overall, the findings suggest that health visitors privilege professional judgement in their work with families, yet increasingly experience a lack of willingness within themselves and others to trust in and listen to it in their decision-making. The work of Sara Ahmed (2004) on how emotions work to secure collective feelings could provide us with a new lens through which to understand this phenomenon. Through her work on emotions and their role in making distinctions between the inside and outside, she conjectures towards the processes of marginalization within our society allowing us to see the limitations and possibilities of health visiting practice to influence this.

The findings so far have focused on the accounts of the health visitors. In the following chapter (Chapter 7) I will consider the accounts of the mothers who took part in this study

who provide an additional and different contribution to thinking on health visiting practice and its implications for both them as mothers and their children's health, well-being and welfare.

7.0 Introduction

This chapter explores the experiences of mothers, their relationships with health visitors, and how they negotiate and manage their children's health and well-being. It explores how mothers work to construct themselves as 'morally adequate' in their accounts through displaying knowledge of health practices which are dominant in public health strategies, for example, around healthy eating and breastfeeding. It considers how mothers monitor and judge their children's health and well-being in relation to changes from the child's own normality and that of the wider population of children. I explore mothers' use of comparisons with children and their families who they know and health technologies such as weight distribution charts, in their judgements. I consider how mothers speak about their relationships with other people, including friends who are mothers and their own mothers, and how these influence the ways in which they themselves mother. In line with this, I also look at how mothers differentiate between these relationships and their influences and how they relate to health professionals and their influence on how they care for the health and well-being of their children. I consider the stories mothers tell about their experiences of caring for their children's health and well-being and explore what these can tell us about vulnerability.

To recap, twenty mothers, in total, took part in the study. As I have discussed in Chapter 4, the majority (18) of the mothers who took part in the study had been categorised with a Core HPI, through health visiting work. This means that they would have been offered a programme of universal contacts provided for all families, with no additional support²². A minority of mothers (2) had been categorised with an Intensive HPI where they were deemed to require additional and/or multi-agency support. My analysis of the health visitors' accounts in this study suggests that parents categorised with a Core HPI, or indeed an Additional HPI, although potentially vulnerable, are unlikely to be understood as

²² Due to ethical and practical difficulties experienced in the fieldwork it was not possible to confirm this for 6 out of these 18 mother respondents. While this is the case, all of these mothers accounts strongly suggest that they had been categorised with a Core HPI.

‘vulnerable’ families where understandings of vulnerability within current policy and practice are dominated by a discourse constructed around risk. The accounts of the majority of the mothers interviewed in this study, then, are not those of mothers who have been categorised as vulnerable where vulnerability is constituted through concepts of risk which are dominating contemporary public policy. Indeed, such is the dominance of this discourse that, to an extent, accounts of all other experiences of vulnerability in motherhood have been silenced (Foucault 1980:131). I experienced concern in the early stages of my analysis that to suggest that the mothers I interviewed were also expressing experiences of vulnerability might be understood as naïve in the context of children in our society who were experiencing the effects of inequality, neglect and abuse. These mothers were by no means ‘on their knees’, unable to cope with the demands of being new mothers. The introduction of the policy that health visiting services should be targeted, however, necessitates a separation and division of the population of children and families into those deemed in need and those who the state believes to be capable of parenting without state intervention. By drawing on these different understandings of vulnerability as inherent in motherhood, from the accounts of the mothers who participated in this study, it is possible to consider how a narrow focus on vulnerability as risk can act to marginalise and stigmatise.

There is an irony in this study of Hall 4 which I think is worth noting and which illuminates the study findings reported in this chapter. While the topic of the research was presented to mothers as about their experiences of health visiting and contact between mothers and myself as the researcher was often through health visitors, the majority of mothers (although not all) who I interviewed did not initiate talk about their experiences of health visitors or talk about health visiting at any length. Often their accounts retained an air of ‘consumer satisfaction’ where they would refer to positive characteristics of their health visitors such as they were ‘nice’ or ‘friendly’. This made accessing the ‘dailiness’ (Apthekar 1989:43, cited by Edwards and Ribbens 1998:11) of mothers’ lives and their negotiations around their children’s health difficult. It was only in the analysis stages when I started to think with the ‘stories’ which they told that embedded accounts of mothering, where their professional interactions were shaped by the policy context of Hall 4, started to reveal themselves. At the same time, the stark absence and marginalization of health visitors in mothers’ accounts

provides data, of a similar nature to interpreting silences in research (Poland and Pederson 1998). When mothers did talk about health visitors it was mostly in reference to the early days and weeks after their baby was born, with a few of the mothers having difficulty remembering the name of their health visitor and being unsure whether they still had a health visitor allocated to them. Studies have shown that mothers categorized with a Core HPI are unlikely to have contact with their health visitors beyond four to six months after a baby's birth unless it is self-initiated (Hogg, Kennedy et al., forthcoming).

7.1 Mothering and keeping children healthy

The majority of mothers interpreted researcher questions around health in relation to their lifestyles and their role in encouraging their children to engage in these similar healthy lifestyles. The focus was on food, sleep and cleanliness and was embedded in the daily routines of the families. In this way their accounts showed a nuanced understanding of the extent to which their children engaged in healthy lifestyles – such as when Mother 20 talks about her daughter refusing to eat any fruit but bananas, but eating dried and pureed fruits as alternatives. In this way, the mothers displayed extensive knowledge of health relating to lifestyle factors which have been promoted through contemporary health promotion strategies such as eating fruit and vegetables and breastfeeding:

Keeping them healthy. ... probably one of the things is we certainly try and watch what they eat. I've always ... I breastfed them both with an intention of doing it for, you know, as long as I could. I predominantly cook all their meals and we cook them and then I cook up big batches of stuff and freeze it for them. We're very aware they're solid little kids, they're never going to be little whelps, so, you know, we're aware of the ... of that and restrict to a certain degree, you know, what they have, make sure that their portions are a decent size. And the same at nursery, you know, they don't always get seconds, and stuff like that. We try and keep things like treats ... you know, treats are for the weekends, rather than sort of standard practice during the week. So ... and we try and eat, get them eating fruit and veg. [Daughter] refuses to eat any fruits but bananas, but ... except she'll eat dried fruit and she'll eat pureed fruit, so we get that in her, and [son] will eat any fruit that comes his way. (Mother 20)

About keeping them healthy? I suppose the first thing is, making sure that they eat well, so we all have breakfast in the morning and eat cereal. I make a point of them eating cereal or something and they do, actually. I think they naturally like to eat it, anyway. And then making sure that they eat fruit and vegetables, that's another thing, and drink milk and what have you, and I suppose the other thing to do with

their health would be making sure they get plenty of sleep, which is quite important. Make sure they're clean obviously, although that's kind of tricky because they're typical children. I suppose the thing that I try and focus on probably more than my husband is keeping some kind of routine to that. I find if they have a routine then they tend to behave a lot better, if you know what I mean. And if they get enough sleep, they've got enough food and they've got a routine then they will kind of be good! (Mother 11)

Monitoring their own child's development and behaviour allowed mothers to judge the effectiveness of their daily practices. In conjunction, they spoke about judging their own child's development in relation to other children. The majority of mothers did this through direct reference to other children they knew, with most also implying that they judged this against wider norms of child development as this extract from Mother 8 highlights through her reference to her son being 'on target weightwise' in reference to the measurement of her own child's weight and the charting of it in relation to other children within the population through the use of child development weight distribution charts:

Food is something I do on a daily basis, worry about whether he's having enough or too much, and whether he's kind of on target weightwise. I'm not so much worried about height because I see him round other babies all the time. You do ... food is one of those things where you just have no idea whether the portion sizes are right. (Mother 8)

Using stories, mothers constructed themselves as knowledgeable about their child's health through dominant discourses shaping child health which were both medically (for example, mentions of symptoms and relating these to concerning childhood illnesses such as meningitis) and socially-orientated (for example, articulations about child protection); and by accepting and rejecting dominant ideas about what makes a child healthy, for example, around breastfeeding. The stories commonly featured the mother who had become aware that her child was experiencing ill health, the child who was experiencing symptoms of illness or had had an accident, and the health professionals with whom they interacted in relation to the incident. The stories function to illustrate the validity and authenticity of the mother's own assessments of their child, based as they were on being present as the child became ill and their ability to then judge what s/he was experiencing to require medical intervention. In seeking this intervention, mothers spoke about how their assessment of the situation was re-evaluated by health professionals who brought a different knowledge to the

situation – based on their awareness of the possibilities which might explain what the child was experiencing. The stories, in the most part, conclude with the mothers restating their own position as having acted appropriately based on their knowledge of their child's health through caring for him/her directly both every day and on the day the ill health/accident occurred. Choosing these stories, and their particular telling of them, enabled them to construct their knowledge of child health as one influenced by closeness to their child and acute awareness of when changes to their health occur, and in this way to differentiate it from the knowledge of health professionals. These extracts from the accounts of Mothers 1 and 15 provide two examples of these stories. These long extracts illustrate the nature of the stories which the mothers told where they often recounted directly their memories of the verbal interactions they had had with health professionals, how they had contrasted with one another and the very personal nature of their own knowledge of child health based on, as it is in the stories, a closeness to their own child. They are necessarily long as it is in their telling that the relationships of the stories are revealed. It is through these relationships (both short and longer term, and personal and with professionals) that the mothers both construct themselves as 'morally adequate' through the care of their children's health and well-being. They also contribute to the telling of the larger analytical story about vulnerability, mothering and child health and its relational and negotiated forms with the role of emotion in the stories playing a particular role:

... I was on my own at home and at 6 o'clock in the morning he started projectile vomiting which was scary and I was kind of okay and he stopped being sick and I thought, that's okay, it was just a one-off. ... when [my husband] came back, and [my husband] was a bit, "Ah, I don't think you need to phone NHS 24." And I was, "No, I'm going to phone NHS 24," and over the course of the conversation I said something which was, you know, set off alarm bells about meningitis because the nurse was saying, "Right, we want to send an ambulance around," and I was like, "Oh, I think that is a bit of over-kill, I think we'll take him to [children's hospital].". And she said, "Well, if you are concerned on the way there, just pull in and dial 999." And then he was quite sick again and by the early afternoon I was just about to phone NHS 24 ... That got me really kind of panicky and, mm, actually it was interesting because [my husband], was really, "Ah, for goodness sake, he's just sick," you know, and I felt I was trying to listen to my instinct that was saying my baby is sick and he's not right, and he's not just being sick, his demeanour is not right. And then on the one hand having this NHS 24 nurse going, "Get an ambulance," and on the other hand having my husband going, "Ah, for goodness sake he's fine, let's just stay and I'm sure it will resolve," and so there is a lot of tension there for yourself as a mother about your, you know, you wanting to

prioritise your baby's health and how best to do that. Anyway, so we went along to [the local paediatric hospital] and a nurse first of all checked him over and heart, and heart rate and all the rest of it, and then we waited around for a paediatrician who was really good, and just gave him a really thorough check over and basically told us what he was doing, he was looking for signs of something that would show that there was something majorly wrong, a kind of blockage or something, or whether this was just kind of sickness, and but he said, "You know, you have done absolutely the right thing, we are here 24/7 and we're always particularly concerned about young babies" etcetera. So you didn't feel like, "Oh god, we have wasted their time", because ... you don't want to be wasting their time. (Mother 1)

... she had diarrhoea for actually 8 days, and I thought that was really a long time, and she was fine, I knew that she was fine ... you know, if you speak to the health visitor and you say she has had diarrhoea for 5 days, oh well, if it goes on for any longer you need to get her checked, so after 8 days, you think, well I really ought to go and take her down. ... Went in to see the doctor and the doctor said, you have requested an emergency appointment for your daughter and she looks like the picture of health to me, and she then went down, she was supposed to have her injections, and I said, "Is it alright for her to have her injections?" and she said, "Well, yes, I don't see why not, what does the health visitor say?", and I said, "Well, they say it is fine if you say it is fine," she went down to speak to the health visitor and shut the door so that I couldn't hear. ... because she had had diarrhoea for actually 8 days, and I thought that was really a long time ... so after 8 days, you think, well I really ought to go and take her down ... It is that sort of distance kind of thing, I think, you know, that more new style of involving you in discussion, I think is more constructive. She had her injections, and, but I was left there thinking, well, what is she saying, you know, "This mother is an idiot, the child is obviously fine," or, is she saying to them, "Why are you referring this baby up to me there is nothing wrong with her?", you know, you just don't know what the situation is, so either it is something that could be said after the event or she could say to me, "Just don't worry in the future. Leave it as long, unless she has got a temperature, or she is limp, don't bother us," you know? (Mother 15)

It is through the expressing of emotions, for example, M1's use of the words 'scary', 'panicky' and 'a lot of tension' and the emotions 'between the lines' of the mothers' accounts which can be seen in their narrations of the stories. For example, M15's story suggested embarrassment and discomfort in her interactions with the doctor, worrying that she thinks, 'this mother is an idiot, the child is obviously fine'. By telling these stories the mothers are displaying their competence in decision-making in relation to their child's health where their knowledge is experienced as marginal in relation to health professionals' (medical) knowledge of child health which is executed through the structures of the health service. Each of the stories suggests tensions and contradictions in knowledge between the

different characters of the stories, the telling of which progresses the stories. The literal shutting of the door in the story of Mother 15 is recounted as an action which separates the mother (and her knowledge of her child's health that day) and the health professionals' expertise in an inside/outside move. At the heart of each of the stories is that, above all else, it is the child's best interests which is the preoccupation of all those concerned. While mothers construct themselves as competent, this sits alongside expressions of fragility in their accounts, such as is revealed in this story by M19 where she talks about 'doing my best' and feeling that she is being 'rip(ped) apart':

He goes to the physio, he was moulded when he was in the womb. His head was a bit squint and his foot was bent up and all that ... I have really felt quite judged by the physio that we have been seeing and you know, you do all the exercises and all that and you go along, and she kind of goes, "He is not getting any better, you know." And you are doing [the exercises], "You need to be a bit more full-on with his exercises", you know, and you think, you know, "I am doing my best" and the exercises make him cry and I spend my whole life trying to get him to stop crying. So, why would I want to make him cry? And I could see, you know, I am pretty feisty, and you know, I don't, you know, I am quite confident, and I am used to dealing with people who are feisty and, you know, but I could see that if there was somebody who is possibly not possessed of those sort of attributes or whatever, might just go, "I'm not going back", because why would I want to go along and have somebody rip me apart for what I've not done, when you have actually done it? (Mother 19)

This observation was reinforced in some of the mothers' accounts where they constructed themselves as competent and rational through their professional background, but 'vulnerable' in their role as mothers of newly born babies:

I think at first the breastfeeding bit was quite difficult. It is the hardest thing I have ever done, breastfeeding, and that is including degrees, and MBAs [Master of Business Administration] ... (Mother 19)

Mothers often recounted stories of feeling judged by others, most often health professionals. In these stories this was often expressed through articulating how their knowledge of their child had conflicted with the health professionals' medically-orientated knowledge. In each of these stories the mothers are pitted against the professionals and their relationships with the professionals, although differentially positively and negatively, which, although initiated as help-seeking relationships where mothers are seeking the expertise of the health

professionals, are always constructed through processes of negotiation between the mothers and health professionals.

7.2 Legitimate knowledge about child health

The mothers spoke about their understandings of their own family circumstances as an important factor shaping their knowledge of child health and which differentiated it from health professionals' knowledge. Mothers often used emotional terms in their accounts to illustrate the impact of professional knowledge being applied without due consideration of individual family circumstances as Mothers 9 and 10 do here when speaking about their experiences of breastfeeding. Again, the role and use of emotion is prominent in the telling of these stories, for example, M9 was 'frazzled and upset' and M10 referred to 'guilt' and was 'disappointed', with mother 10 also referring to the physical/embodied nature of her experience: 'I just couldn't bear two sets of pain at one time':

I think that because of their guidelines that they have to push breastfeeding. They'll push it at the expense of the mother who, you know, somebody did say to me in the hospital, the hospital's midwife ... if you were to suggest topping up the formula nobody would let you, or maybe they were, but they're not allowed to, which I think is absolutely ridiculous because ... I don't know, if you've got somebody that's so sort of frazzled and upset. And because I'm a bit older, I was able to say, and I would just say, "Right, well, what I'm going to do is I'm going to express and top up the formula, because, you know, she's not able to get anything from me." And they said, "Fine, that's a good plan." But they wouldn't necessarily have suggested it, so because I had the confidence to say that they were quite supportive. But I know people that didn't, and had an awful time and they seemed to let the baby lose a dangerous amount of weight and the person was really, really upset and, you know. And I just think that there's something wrong with that policy there.
(Mother 9)

I gave up breastfeeding after five days because I actually couldn't sit for more than 10 minutes [due to pelvis injury] ... I was disappointed because I started breastfeeding with [name of second child] but I just couldn't bear two sets of pain at once. I thought I'm not going to do this. ... I guess I got a bit bullied the first time but I wanted to do it [breastfeed] anyway ... there's a lot of people where there was a lot of guilt tied up with giving it up and I felt like that the second time but actually I felt, you know, you've got to do what's best for you as a unit, as a family.
(Mother 10)

By constructing themselves as confident in the face of professional opposition, mothers worked to legitimize their decision-making as being in the best interests of their child even

when it sat in opposition to knowledge they were experiencing as mothers as privileged by professionals (often legitimized through evidence-base and perpetuated through public policy), for example, around breastfeeding. These mothers' constructions of themselves as having agency and being active decision-makers in itself acts to cover the tracks of 'vulnerability' as they actively work to rationalize, and through doing so, downplay, experiences they have found traumatic. My analytical journey suggests that it is easy to think about these experiences as conceptually and analytically unimportant through their short term nature and the likelihood that these mothers would have other resources (financial and personal) to draw on. As I discuss in Chapter 4, my overall analysis, however, suggests that these stories of 'vulnerability' are important and it is for these reason that I draw the reader's particular attention to them.

The majority of mothers, as well as speaking about the importance of caring for their own child, referred to other contributory factors informing their knowledge of child health. Just as the health visitors referred to the codified nature of their knowledge of child health, so did many of the mothers. This included drawing directly on references to research evidence, and to opportunities they had taken to learn about an aspect of child health. The accounts, Mother 8's in particular, suggests an unintended consequence of how evidence-base can impact on mothers is when they use it as they work to achieve the status of 'good mothers'. This included engaging in 'health-promoting' practice, for example, breastfeeding (M8) and Mother 3's work to access research to enable her (through being metaphorically 'armed'²³) to be a consumer of health services and to choose the service she wanted where resources are limited:

I'm proud that I breastfed for six months and that I managed to do that. Even though I hated doing it in public and I just had to grin and bear it, basically, so you know, I breastfed him in whatever café I was in, and I felt really self-conscious but I was committed to doing it. So I'm proud that I did that, and I think it sets him up for good health, because you know there's so much research obviously about diabetes and asthma and obesity and asthma, and you're just protecting them against all those things. I know it's not 100% foolproof but it will all help. (Mother 8)

²³ The use of battle and war metaphors as a strategy of persuasion has been documented (Wilson, 2003).

... we've used the internet ... I actually contracted chickenpox when I was actually pregnant with [child 1]. We did tend to look that up quite a bit, only because we were armed and ready because of Scottish healthcare for pregnancy is not the best and to be armed ready with information sort of saying, you know, we want this or do we apply again for a scan ... so it was just more information, because we kind of felt actually disturbing a GP for that was not appropriate and I wasn't sick and actually it was just information gathering ... (Mother 3)

How the mothers spoke about research evidence differed from the health visitors in that this was mainly generated (although not always) through an interest borne out of what they were experiencing themselves or in caring for their child and, in turn, applied to their own personal circumstances. In conjunction, they used evidence to support them in their mothering, for example, when they were making decisions in relation to their children's health and well-being (M15) and as a strategy to alleviate worry and anxiety (M13):

And I have now reached a point where I genuinely think, I look round at what people are saying and then I think well, I think this is the best bit, based on what we do, what I am like, you know, what I, you know, these are things that I am genuinely worried about, and these are things that I don't, which don't really bother me. I don't think that sterilising now is necessary, some people do it, some people don't, apparently in America they don't even have sterilising, so. Whereas I would worry about I don't know, you know not cooking things so long that all the vitamins had gone, you know, things, there is just sort of a process of prioritisation ... (Mother 15)

I know, there is so much information, I know, so like, while I was pregnant, initially I would read and then I gave up, it was like, oh, how much can you read, but then now, I think that you can't actually bank so much on your health visitor or GP because they just give you an answer that is like, they might know better maybe, but when you come out of it, I don't come out convinced. So, and I feel that they cannot convince you because maybe they don't even have the time. So, they just say, "Don't worry," but that doesn't stop me from worrying. So, to know more I have to do some homework myself. So, I would think for any mother, you know, if they don't do their own homework, then they might not have all the answers that they would want. So. (Mother 13)

For mothers, their knowledge base was process driven through their relationships with health professionals and information from different sources, including the internet, and family friends who were health professionals, through which they developed a nuanced knowledge of concerns affecting their own child's health and well-being:

... it seems like an area that there is a lot of conflicting advice on, and there is a lot of holes in the research really. ... when we saw the consultant this time, it was a different consultant who gave us a different set of advice, and this might be reflective of how well we have remembered what we have been told, but he gave us a different, a different understanding of the facts ... we have friends who are medics who we kind of chew things over with, we have, and then there is the internet, of course. (Mother 2)

This process of knowledge accumulation and assimilation about child health extended to the mothers' own mothers and other mothers who also had young children concurrently to themselves. Although mothers spoke about their own mothers as having useful and genuine contributions to make, their knowledge base was often displaced as overly experiential and lacking contemporary thought about what is best for children's health:

... my parents have been very good, both of our parents are very good at not giving us too much advice. And mum says that she ... we've had discussions, I guess, with them at times ... And they'll say... and we'll admit to, "I'm sure we do things that you don't agree with," and they were like, "Yeah". But, you know, but that's fine, because, you know... [Laughs]

*CK: Things change.

*Partner: Well, yeah. [Emphatic tone]. (Mother 20)

This meant that it was best received when mothers understood advice given as empathetic over directive, and hence providing them with emotional support which they could not necessarily access elsewhere:

The best thing was that my mum didn't give me any advice when we were home with the baby. ... The only comment she made in 4 months was twice she said to me, just remember that you were bottle-fed, all of my children were bottle-fed. And I knew what she was saying was, don't get too frantic if the breastfeeding doesn't work, and that was the only thing she said, apart from that she didn't say anything and that was great. ... if the phone went and it was my mum, I could just pick it up, because she would just be saying, you know, do you need me to bring round more soup, or something, you know it was much more domestic which was what I needed. So. Yes, I think the best advice to give to new mothers is just to make soup for them and don't interfere too much because you find your own way. So. I don't know how easy it was for my mum to say nothing but I'm glad that she did. (Mother 4)

Mother 4 gives emphasis to the importance of this emotional support when she contrasts her mum's approach with her sister-in-law's, again highlighting how knowledge for the mothers

was validated through relationships within which they were generated, and as such cannot be understood in isolation of these:

Whereas, my sister-in-law, who is a very nice person, but she was always, and she was just trying to be helpful, but she was always, “Oh, the baby needs this, the baby needs that, you should do this, babies need to be in this room, oh, the baby is looking a bit skinny, she is looking a bit white, and when did you last feed her?” she was just trying to be helpful and she was anxious because she is just, she’s just a bit more anxious in her nature than I am, there are sometimes if the phone went and it was my sister-in-law and I thought, I can’t speak to her, because I can’t deal with this anxiety coming down the phone. (Mother 4)

Mothers’ interactions with their own mothers, while often not providing them with a solution to the problem they were experiencing, acted to bolster the emotional support they were receiving, particularly as it was felt to be more accessible and responsive:

*CK: And you were saying that your mum has been a good support?

*M7: Yeah

*CK: What kind of things does she do?

*M7: Like, this morning I phoned her, and I was like, I think [daughter] has got hay fever. Did any of us have hay fever? And she said, well, go over to your pharmacist and she will be able to help you, or ask the doctor. So, just things like that because none of us had hay fever when we were young, so she really couldn’t help me on that, but then other things like I don’t know, what do I feed her for her first food, or what milk do I give her? And stuff like that, rather than phoning your health visitor at back of ten at night, thinking what should I give her, I need to get it for the morning, what should I give her, so, she kind of helps with things like that. And she will take [daughter] off my hands as well, just to help, like some days she just cries non-stop and you are just so tired, and so I say, “Mum, can you come here for an hour while I have a wee sleep?”, so it is really good. (Mother 7)

For mothers, they were able to judge their own child’s development through comparisons with other children. This often involved visual comparisons of growth and extended to comparisons of mothering practices, as Mother 12 does where she compares her own baby and practices around nutrition to another mother she meets at the breastfeeding clinic. Similarly, talk was an important aspect of these comparisons where mothers would exchange stories about their children and, by doing so, engage in a similar rapport talked about by the health visitors where they were able to gain reassurance through the process:

I went to the breastfeeding clinic at the hospital, [child] was four weeks old, and the girl actually who had been in the bed next to me in the hospital she was there as well, and honestly [child] looked like this big baby next to this baby because he was really struggling and he'd hardly put on any weight at all, he looked like a newborn, and I just thought, oh, look at me, he'd been latching on properly he looked the picture of health when I saw him next to this baby and they said to her, "What have you been ... ?" or, I don't know whether she said to me in passing, but she said that she'd eaten a bag of hula hoops the day before and I thought you can't breastfeed on hoola hoops, so at the group a lot of people sort of suggested well, maybe you should have a sandwich in the afternoon, and just little things like that. (Mother 12)

It is just quite useful to go along and talk to other mums about their experiences and how their kids are developing. The mums that go along the babies tend to be about, when I first took her along she was about 8 weeks, but some mums go along when their babies are 4 or 5 weeks, and then they maybe go up to about 8 to 10 months. And most people stop going to it about that stage, and it is just useful and reassuring to talk to other people who are going through the same experience at the same time. (Mother 17)

Many of the mothers constructed the conversations between themselves and differently and in comparison to those they had with health visitors. The main difference was that conversations with mothers were less directed and allowed opportunities to express emotions, such as, 'you can have a really good old whinge' (M3), whereas health visitors' advice was often constructed as lacking in attention to individuality:

... other mums ... because you can have a really good old whinge, I think, and you can compare what other health visitors might have said and compare what you're doing and I think they just understand you know, more understanding and you haven't got to go down I suppose the professional route of telling you that you know, this is what we should say to you ... (Mother 3)

... actually, the biggest single support is talking to other mothers. I think quite often health visitors, a lot of them go by the experience of their own children, which is absolutely valid, but it can be a long time ago, and they have only had that one type of, or two, or three types of baby, you know what I mean. Whereas, if you talk to a lot of other mothers you will always come across somebody who has got the same problem, eventually. And if you don't, you just get the kind of, it is the currency of it, other people going through the same thing. (Mother 15)

The blurring between mothering knowledge and health professional knowledge was illustrated by a story told by Mother 3 where she contrasts her own knowledge of child

health with the health professionals whose knowledge, she suggests, is out of step with current thought on infant nutrition and more likely to be based on their knowledge of child health drawn from their own experiences of mothering or fathering. The mothers' accounts often showed evidence of pressure which was perpetuated by the notion that practices are good or bad or hierarchical which, for mothers, expressed itself in their belief that there was a 'best way' (M12) to care for their children:

... it's the conflicting advice you get from people. I'd been at the doctor's [he was] quite an old fashioned doctor, ... he'd sort of dropped off a wee bit on the chart and the doctor said, "Oh, he needs some banana, a wee banana or something," and he was twelve weeks old and I knew, I know you don't give a banana to a twelve-week-old baby, and the next day I was at this group and I just thought I don't know what I'm doing, I'm trying my best and thinking I'm feeding him the best way and I just started crying I was just kind of confused by it all ... (Mother 12)

Although mothers spoke about the value of other mothers' knowledge, at times in preference to health professionals' knowledge, the differences between this and health professional knowledge were alluded to by a few of the parents who referred to friends, often mothers, who were health professionals upon whose knowledge they had (or would be likely to) draw. The advice that was given by these friends was differentiated by mothers from the advice they might get from other friends and family and legitimized through the person's status as a health professional:

One of my good friends is a pharmacist and she works for NHS 24, so rather than phoning up NHS 24, she's got a young, she has got a toddler, so, she was on the phone to us socially anyway, so, I think I would have phoned her rather than phoning up NHS 24, because she always said, if you need anything, just phone 24 hours a day, you know it doesn't matter, just phone her at home, or phone her mobile. (Mother 4)

*M19: ... I felt kind of okay. And I just thought, why am I here? [In hospital after the birth] I could be at home, and I just kind of wanted to get home and get on with it.

*CK: Yeah.

*M19: But then there are other mums who I have spoken to who have said it was really good having the reassurance of other people around. You know, having the midwives around so if you were struggling or whatever, but I suppose, it depends. I mean, I have got a really good pal who is a midwife, so I would phone her up, if we were having any problems, I knew we had a support network at home ... (Mother 19)

Through these examples in the mothers' accounts they constructed the knowledge of mothers themselves, although valuable, as different from the knowledge of health professionals.

7.3 Judgement and normality

In this section I explore further how mothers constructed the differences between their own knowledge of child health and health professionals' knowledge. All of the mothers spoke about their interactions with health professionals. Just as mothers spoke about the importance of being able to compare their child's development with other children's, they highlighted how health professionals were also able to do this, but based on an experiential knowledge drawn from working with many children and families over time. In this way, although mothers spoke about comparisons they made with norms, it was the professional knowledge of health visitors which allowed them to contextualize this. Again, many of the mothers used emotional references to illustrate the impact which the knowledge of health professionals, and the experiential nature of it in comparison to their own, had had on their experiences of being mothers caring for new born babies. The mothers' stories are about their experiences as mothers and illustrate how vulnerability is constructed through professional work:

... that was when the weighing of the baby started, and she wasn't gaining the weight very well, so luckily the health visitor at [name of practice] was another one who was, as I say, very confident people, and just a really nice person, very grounded and helps to keep you grounded when you are thinking, oh, my baby is not gaining weight as it should. But, you just felt that it was okay, without making a big thing about it. You know, being concerned but not making you nervous. So. Or more frantic than you were feeling already. ... We [now] go down once a fortnight to the baby clinic to get weighed, but we just drop in, it is not formal appointments. And if I miss it, it's no big deal. It is my choice to go now. And, [name of child] has a funny growth pattern, she has a fortnight where she puts on very little weight and then the following fortnight she puts on an enormous amount of weight, and that pattern has been maintained for the whole 19 weeks of her life, so we have just realised now that is just her pattern and when she has a low weight gain fortnight there is no point in being upset, because a fortnight later she will have an enormous weight gain. And that is just how she grows, but of course we didn't know that at the beginning. So, yes, I just drop in and get her weighed there every fortnight. And I just like to know. I just like to know how she is getting on. I mean, they have told us that as long as she has got nice skin and she is alert and she is smiling and

she is interacting and she is happy then she is getting enough milk and all these things are always fine, so. (Mother 4)

This was emphasised by mothers when they spoke about how as their own knowledge developed they drew less on comparisons drawn from wider populations, either through weight distribution charts or their interactions with health visitors, and more on their own knowledge and experience:

So she would say, “Do you want to weigh her?”, and with [name of second child] we’ve never worried about her growth rate so actually, I think we got her weighed very few times. The first time you are paranoid, but the second time, and you think, “Oh, it doesn’t actually matter.” Because I had a very small child and a big child. We knew this one was doing fine. (Mother 10)

The majority of mothers in their accounts suggest that just as their knowledge of child health was individualized to their own circumstances, neither was professional knowledge uniform. All the mothers spoke about their interactions with their midwives and health visitors. Mothers spoke about how health professionals, as well as they were able to apply their professional knowledge to the mothers’ own situations (and bodies), how they did this differed. The majority of mothers described midwives as being more ‘hands-on’ in their approach and health visitors as focusing more on the emotional aspects of their care, constructing their mothering experiences through the interaction of health professionals with both their bodies and minds, which would become known through strategies such as examinations by midwives and health visitors’ techniques for engaging mothers in talk:

... she made me lie down on the sofa here and she checked my stomach and was basically checking to see if your uterus had gone back to normal. And that was good. You were very conscious at that time that a revolution had just happened to your body, and your stomach looked awful and felt strange, and it was very reassuring for someone to actually come and touch it and go, “Oh no, that’s nice. It’s all contracting back. That’s lovely.” That was kind of a relief. (Mother 8)

So when she came it was quite a different, I could tell the difference sort of, because the midwife was very hands-on, literally checking your nipples and things like that, and then when the health visitor came it was kind of like, you could tell that she wasn’t going to doing anything like that! A bit more business-like, and there was more chatting about ... maybe more chatting about emotional things and stuff like that, and just explaining the whole thing about, well, “We’ve got the clinic, we’ve got a clinic every Monday there’s a weigh in if you want to go,” so that was good. (Mother 12)

The most notable differentiation that mothers made between their own knowledge and health visitors' knowledge was based on the premise that health visitors' knowledge was shaped by a wider experiential base than their own, particularly when they were new mothers. This portrayal mirrored the health visitors' own accounts. The majority of mothers spoke about two aspects related to this theme: reassurance and judging normality. Mothers spoke about health visitors' abilities to reassure as, as a new mother, they felt that their knowledge of child health was still limited. In this way, the majority of the mothers' accounts suggested that mothering for them was learnt and practices developed and honed:

... I think a lot of it initially when it's your first child is the reassurance. And it's the ... just giving you ... helping give you the confidence that what you're doing is right. So that they don't tell you stuff, they suggest stuff. They give you options of how to ... of what your alternatives are, and things like that. They'll use suggestions of what other people ... well, here's what somebody else has done, and stuff like that. So it's very much they let you lead what you're doing, but are willing to offer suggestions or any help that you might need ... (Mother 20)

*CK: So ... your first contact with your health visitors, how did you find it?

*M5: I found it useful. Again it was just, you know, to have that sort of somebody with a bit of experience, you know, so you could just ask any questions and you know, [name] had a, I think it was in one of her wee folds, it was just like a wee blistery thing, I think I just hadn't maybe dried her properly and you know, I just, it was good to have somebody just to check it out and say, "Well, don't worry, it's fine," and so it's just that again, it's the reassurance because you just don't know ... (Mother 5)

The emotional support that many of the mothers spoke about as being a crucial element of the support they received from their own families, was also an aspect of their relationships with health professionals, particularly during times that they were finding stressful, such as when their child was unwell, or, in the early days and weeks in particular, not feeding well:

... one of the midwives who came round here when [name of baby] was born, when I was having feeding problems, I think actually she just made everything worse. It was just a really awful situation, and then my normal midwife reappeared. And we were about two weeks, [name of child] was about two weeks old. And I opened the door looking really distraught and my normal midwife was there and I just wanted to hug her, oh, thank goodness you are back, and it is like normality came back. (Mother 4)

Many of the mothers also spoke about their health visitor's ability to make judgements of normality based on their knowledge of child development. As the health visitors' accounts suggest, mothers also felt that it was the health visitor's ability to be more objective and to judge in relation to their experience of other children's development that differentiated their knowledge of child health from their own. This was also what they, as mothers, spoke about valuing:

... being a first-time mum as well, you know, you're kind of, you don't have a clue, I mean, it doesn't matter how on the ball you think you are, I mean, I don't know, you're just learning all the time, really, and sometimes it's just nice ... that's what I quite liked about having the eight-month check, particularly, was the fact that there was this appointment that you had to go to, to see that your child was developing kind of within the realms of normality, because, I think had it not been my first child then I wouldn't be so bothered but, I think the first one it's really important because you don't have a clue, I mean, they're all so different anyway ... but if you don't really know what's normal then it's difficult to... but it's nice to have some kind of professional going, you know, the fact that your child isn't walking at three is perfectly fine, I mean that's an extreme example, but you get my drift. (Mother 11)

And obviously, in those days they did their various checks at various stages which was a great advantage to us at that time for [child 1] because, obviously she was prem and we just wanted to check that she was developing sort of ... to use the term 'normally', in loose terms but they also picked up that she needed speech therapy which they wouldn't now, unless you know as an experienced mum, shall I say, you know that ... I know they should be doing this but as a first-time mum I thought it was quite ... you know, that sort of, "Oh, well, I can understand her," you know, that sort of ... I didn't see it as a problem, so it was a great advantage that they were still doing those sort of tests. (Mother 3)

The importance and value placed on health professional knowledge by mothers themselves is illustrated by a story told by Mother 8. Again, similar to many of the other mothers when telling stories based on caring for their children's health, she uses emotional terms to describe her discomfort at trying, as a new mother, to ascertain her son's weight. She contextualises this in her story when she speaks about the GP's request for her son's weight. By doing this, she uses the story to illustrate the differences between her knowledge of child health, as his mother, and professional knowledge. Her description of the different settings in which she attempts to ascertain his weight – her home and unsupported in the health clinic – highlights the role of place in the generation of knowledge about child health, where

it the clinic and the opportunities for interaction it provides that allows for the possibility for wider comparisons of child development:

... basically, they put the scales for your baby out in the waiting room kind of twice a week, and you have to go into a waiting room full of people who are sick, strip them naked, hope to goodness they don't pee and embarrass the pants off you, or cry. And you're meant to try and get them on the scales and keep them still and write down the weight. And it's just impossible, so I've just not weighed him for about three months. And I will say to my friends, "I don't know how his weight is. I'm doing it on the home scales. I'm getting on with him and getting off with weighing myself and weighing him and trying to work it out that way." But it's nowhere near an exact science. ... What happens at [name of place] is, they've got more help, so somebody actually stands and weighs your baby, helps keep them still. They write it in your little red book and they do their height as well. The only height measurement I've ever had is his birth; so basically in [name of place] the scales just sit in the waiting room and you have to do everything yourself. It's just impossible once you've got a crawler. I can't get him to stay still on the scales let alone keep him still and write at the same time and remember the number. ... So I think I feel slightly aggrieved about that because last time I was at the doctor's they said, "Well what does he weigh?" And I said, "I don't know." And they looked at me like I was a terrible mother, and they said, "Well, that's the only gauge we have of whether he's healthy." And I said, "Well, me too, but you know I can't wrestle with him in the waiting room with everyone watching me. It's just too embarrassing." (Mother 8)

The majority of mothers then constructed their knowledge as different from health visitors, and differentiated professional knowledge through comparisons between midwives and health visitors. They also did this through their comparisons of the approaches which different health visitors took where a few mothers spoke about health visitors who were new to the profession as drawing to a greater extent on codified knowledge they had learned and the difference between this and the application of codified knowledge to their own family circumstances. Through their accounts the mothers also highlighted the value of health visitors being able to build relationships within and across families and the transference this brings for all families over a reliance on codified knowledge only:

... [name of health visitor] it was her first week in the job or something like that, and I remember that, and she was very particular, and she always is very particular to be clear about her kind of, I can't think exactly how to describe it, but you know, she always makes sure that you understand you know what, why she is doing things, what the background is, what the advice is, what, you know, so she was very, I think careful not to, to make sure that we weren't just nodding and smiling, if you know what I mean ... (Mother 15)

I think [your health visitor] treating you as an individual again and listening to what you are saying and taking what you are saying and giving you advice on that instead of just giving you standard advice that's given to everybody [is important]. Sort of actually thinking about your situation that you are in and giving advice on that, was quite helpful rather than saying, "Well the book says you've to do this so that's what you do," they are actually looking at it and saying, "Well you've got this," so, like [name] likes to sleep on his front and all the books say put them on their backs and the health visitors have sort of said, "Well the books, everyone, the health care advice is you get them to sleep on their backs but if he won't sleep on his back then there is not really much you can do," you know? They said, "Have you tried turning him over?", and I would say, "Yes, turn him over, and he just wakes up," and they are quite happy to say, "Well, if he is happy then just carry on and that's fine." Whereas in the past with the very first health visitor that we had, [name] was a bit the same, he wanted to lie on his front and she said, "No, you can't put him on his front, you have to put him on his back and that's what you've got to do." But they [her current health visitors] are a bit more sort of flexible with things. (Mother 6)

As the above extract suggests, a blurring in the distinctions between mothers' knowledge and health professionals' knowledge was again evident with mothers valuing when health visitors were able to recognize and accommodate their knowledge of child health as mothers.

The mothers' accounts also suggested that their knowledge of child health was shaped by an awareness of the risk discourses impacting on professional practice (and knowledge) of child health. A few of the mothers spoke of how they had either worked to shape their own circumstances in line with what they felt was expected of them through professional practice, or how they felt that they had been confronted by them directly in their interactions with health professionals:

And I remember one thing I was quite concerned about was because of the dog, and I was concerned that they would think, you know, that that was kind of some kind of health issue, and I think I was trying to say, "Oh, no, we don't let her anywhere near the baby, and she is very good with the baby," and you know, feeling that I had to kind of justify, so, mm. ... On the one hand, you felt like here is a wonderful, friendly, caring individual who has a fountain of knowledge coming into your home, the other thing was, oh god you know, I better make sure I'm dressed and everything, and everything is kind of vaguely clean, and you know, you definitely felt like I didn't want somebody coming in and going, "Oh my goodness, she's not coping," or you know, "The baby had a wet nappy when I arrived," do you know what I mean? (Mother 1)

In line with this perceived expectation, a few of the mothers told stories through which they illustrated how they had felt that their knowledge of child health, and of the particular circumstances through which their child was presenting to health services, was being framed through a different understanding (and knowledge base) of child health from their own. These stories had similarities in terms of their characters (mums, child, health professionals) and plot (child illness/accident, interaction with health professionals, differences between the knowledge of mothers and health professionals about child health). The mothers, through their stories, articulated very clearly what they believed to concern health professionals in relation to children's welfare and the observations they were making. Whereas Mother 3 had concerns that bruises would be read as a form of abuse and that she was being silenced, the account of Mother 16, who had been categorised with an Intensive HPI, tells a different story where it was through missing an appointment (a relatively minor transgression) that she felt her mothering capabilities were being questioned. While this is the case, both the mothers work in their accounts to achieve 'moral adequacy' through their own actions 'I wouldn't dream of hitting my child' (M3) and/or justifying the actions of others in their accounts 'they are all run of their feet, basically' (M16):

... [child's name] had fallen off her swing and she'd hurt her arm but nothing was obviously broken and I checked it and I thought she's just sprained it, that's absolutely fine ... she was still complaining about it in the morning and I thought well maybe we should probably get this checked out, so I took her up to [the children's hospital] and I wasn't allowed to talk, I wasn't actually allowed, because after we'd checked in and I'd explained that she'd fallen, the doctor just stopped me and said if that's the case she can tell me, and I was like, "Ohhh," and I felt really, really awful, you know that, I felt instantly that I was under suspicion, I suppose, of actually hurting my child ... which I could understand and was quite happy in a sense that they thought my child was intelligent enough to actually tell them what was wrong, but I was there thinking, "Oh," ... And I suddenly thought, "God, I do look like a...," you know, she had fallen off her bike so she was covered in bruises here and had various marks on her back and I was thinking, "Ohh," and I sat down and I just felt awful. I just said, "She fell off her swing yesterday," and so that was quite insightful that, you know, I wasn't ... because it could have been quite ... I wouldn't dream of hitting my child ... (Mother 3)

I had it off the hospital one time because I missed my appointment with [name of son] but he had the chickenpox and I didn't want to take him over, and before that I had missed one appointment, and then I had phoned back up to cancel and make

another one, and then his with the chickenpox I had missed but no cancelled, and then I had to phone back over, and they said, “I feel like referring you to the social workers for neglect,” I said, “Neglecting what? Missing an appointment?”, and they said, “We can report you to a social worker for neglect,” and I said, “Oh, can you, well, you do that then, you report me for missing an appointment,” and they said, “Well, we will make an exception and give you another appointment.” They have no got time to help you. They are all run off their feet, basically. (Mother 16)

A few of the mothers illustrated the blurring between their knowledge and health professionals’ knowledge by drawing on their experiences as professionals – sometimes as health professionals, sometimes not – themselves, to illustrate the dimensions of their knowledge about child health:

I think coming from obviously a nursing background I kind of know when they’re sick, you know, this is not going to get us anywhere [going via NHS 24] and obviously we’ve taken them to the GP or straight to the hospital. (Mother 3)

I work in political-related field. I know that politicians jump on the bandwagon for things and they maybe get hold ... and I’m often quite cynical and I think often as well, you know, people buy into this, and release all these news items where actually sometimes the evidence, scientific, and stuff I’ll read up on ... but it’s the bandwagon and people will jump on and then there’s suddenly there is policy about it and it’s how well has that policy been researched, you know. ... So the second time round I just ... I just actually thought well, I’ve been through it before, so I knew what I was going to do. So when the advice came, say well, that’s a latest – that’s the latest thing that someone has picked up on and ... I think the second time round I ignored a lot. (Mother 10)

For these mothers, there was a distinct blurring between their public (work) and private (family) lives which they drew on as they constructed their mothering experiences in their interviews in what would become public accounts, that is to say, the research accounts.

7.4 Discussion

My analysis of the mothers’ accounts suggests that all of the mothers are telling stories about their mothering and vulnerability. This observation is illustrated through paying close attention to the mothers’ use of terms such as ‘frazzled and upset’ (M9), ‘guilt’ (M10), ‘disappointed’ (M10), ‘I felt really self-conscious’ (M8), ‘I just started crying I was just kind of confused by it all’, (M12), ‘[not making you] more frantic than you were feeling already’ (M4) and ‘it is the hardest thing I have ever done’ (M19) to describe different aspects of their experience of caring for the health and well-being of their babies and young children.

In conjunction, it can be noted in the way that mothers use their stories to present themselves as rational in their mothering (Baruch 1981; Frank 2002; Frank 2006). The analytical challenge, then, has been in revealing them when the dominant discourse shaping professional practice around the construct of risk acts to silence them. In conjunction, the accounts suggest that the mothers themselves work to silence their experiences of vulnerability as they work to construct themselves as morally adequate in their parenting. One way in which they do this is through using counter-expressions to demonstrate their confidence, for example, ‘because I’m a bit older, I was able to say’ and ‘I had the confidence’ (M9) and ‘I am pretty feisty, and you know, I don’t, you know, I am quite confident, and I am used to dealing with people who are feisty’ (M19). These different vulnerabilities expressed by the mothers who took part in this study are important as part of the analytical story of this thesis. They contribute to our better understanding of mothers’ experiences of caring for children’s health and well-being over saying that they are *as* damaging as neglect, abuse, and inequality.

The health visitors’ accounts give us further insight into how hidden vulnerability can become and its potential relationship with class (Duncan 2005; Lawler 2005), in their stories of colluding with the secrecy of mothers who are self-harming or bulimic. They suggest in their accounts that the purpose of the collusion is, in part, to maintain a relationship with the mothers. Wilson (2001) has referred to this as ‘secrets and lies’ (Wilson 2001:298), through which health visiting practice itself can act to mask and undermine what counts as a valid experience of vulnerability in mothering. The complexity of the relationship between class, mothering practices and health visiting work, however, remain little studied and are an area for future research which I explore in Chapter 9, section 9.6.

8.0 Introduction

In this chapter I return to my analysis of the health visitors' accounts. I consider the language which health visitors use to talk about vulnerability and its role in constituting and dividing 'vulnerable' families from all families. I explore how health visitors construct vulnerability through their practice, and how they resist this with alternative constructions which are embedded in their practice as health professionals. I consider the shifts which health visitors discuss where they compare their motives for joining the health visiting profession, with their experiences of the profession now that they are part of it, including their resistances to their practice being increasingly shaped through the practices of and their relationships with social work. I conclude by considering how a focus on vulnerability and vulnerable families has not only brought about a shift to how health visitors work with families with young children but has, ironically, challenged and 'made vulnerable' they themselves as health visitors, and their profession as a whole.

8.1 Concepts of vulnerability in health visiting practice

All of the health visitors used terms which both described and divided families. Terms included 'vulnerable families', 'dysfunctional families', 'needy families' and 'complex families', with most health visitors differentiating these families from the majority of families with whom they worked who they broadly and most often categorised as 'normal families'. At the heart of discussions about health visiting practice were those about the extent and nature of child protection work within health visiting practice:

... a few years ago you had the odd child protection, but I would say the last two to three years the numbers have really increased of children on the child protection register. We have a lot of families in the area who are foster parents, we have quite a few of them, with foster children who are in looked-after accommodation. And with that brings an awful lot more of core group meetings, child protection meetings, looked-after reviews, so, a lot of my work now is doing reports, doing regular visiting with particular families. ... sometimes a core group can meet on a weekly basis depending on how bad things are, it can be monthly, it can be two-monthly, so you have to attend those, you know, children's panel, I sometimes attend those, depending on the families, sometimes they just ask for a report. (HV3)

This was work which health visitors spoke about as part of their professional remit which had come to dominate their professional practice in recent years. It was work which health visitors had to and did prioritise (implicitly) due to legal requirements shaping this area of their practice:

... we might not have trillions of numbers when it comes down to child protection work, but the intensity, the amount of reports, the attendance at hearings and everything else that has to be done by us, is just unbelievable. (HV2)

Now, the more children I have got on the child protection register, the more core group meetings I have got to go to ... I had actually two core group meetings, in the one day, for two different families. And that is heavy. You know, you are having to write reports, submit reports, think about the family, and present yourself at a meeting, take all the information, share information, come away from it, and then do the same for another family. And you are shifting from one set of circumstances to another. (HV9)

Health visitors described statutory child protection work as onerous, time consuming and, at times, exhausting. However, it was their work with all families, and in particular, families where they had identified early concerns, which they were monitoring that they spoke about as most challenging for them professionally and within their practice:

*HV11: I have had ten on the register before in a caseload.

*CK: Right

*HV11: It actually is quite good if they are on the child protection register because they are being very well monitored by social work and myself. It is the ones that aren't on the register, that are borderline, that you are involved in that is more worrying ... (HV11)

Health visitors suggested that these challenges emerged, both because of the quantity of work this process presented and because of the resistance that health visitors experienced from families. Often (and in particular within their current practice context), they felt that the 'relationship' so valued as part of their practice seemed often to be absent or lacking in substance:

I've got a remit that I've got to police them almost ... my feeling is that ... a lot of the time that they [feel they] have to see a health visitor and 'here she is again', and

they are just going through the motions and my feeling for that is because they are not in, they don't answer the door, they forget your appointments ... (HV15)

When there was a shortage of health visitors in any given area the health visitors who were interviewed highlighted that it was child protection work which they and their managers prioritised. Through these processes of workload negotiation, work involving children and families where a child protection concern had been identified, had become a key driver of health visiting practice. While this was the case, on a broader level, health visitors highlighted the subjective nature of their assessments of children and families through which families were categorised as in need (or not) of further intervention:

*CK: Yeah, when it doesn't happen, why doesn't it happen? [Question asked in relation to why a Family in Need [FIN] record is opened in some circumstances, yet not others.]

*HV7: At the places I have worked, I have known it not happen if it has been a developmental delay situation. If it was a child protection issue, it would always happen. I don't know of anywhere where there has been a suspect or an actual child protection issue where there wasn't a FIN record. But, I have known other health visitors to decide not to open a record for a certain child, even if they have got some quite serious health issue going on. And I think that can maybe be because it is so dependent on a health visitor's assessment of the situation, and it might depend on how many FIN records they have got, and what the rest of their caseload looks like, etcetera. (HV7)

*CK: ... the Health Plan Indicators – how have you found working with those?

*HV11: Well, the intensive is very subjective, it always has been because some health visitors, depending on their background, or depending on their experience, would maybe put families on an additional record, on a Family in Need record, when others wouldn't, so it is a very subjective tool. Mm, automatically I think everyone would put a drug-using parent on an additional record, but, for example, depression, not every health visitor would, although she would be working obviously with the mother and child, it would be documented on our information system, but they may not put them on an intensive record. (HV11)

A shift was evident in the majority of health visitors' accounts from a practice shaped through work with all families, generated through the pre-Hall 4 child health programme, to a practice shaped through a focus on child protection work with a minority of families in their caseloads.

All of the health visitors' accounts suggest that their involvement in child protection work was not a new aspect of health visiting practice. Most health visitors talked about this work as a longstanding and important, if not always straightforward, aspect of their practice. The health visitors' accounts suggested, however, that it is their feelings and responses to this work which have changed. One area in which this was evident was the health visitors' responses to the implementation of an assessment tool introduced in the study area close to the time of the fieldwork. The tool had been developed by a team of practitioners and was introduced to health visitors in practice as a general assessment tool. Its development process, however, came at a time of a heavy air of concern about child protection following a local infant death and subsequent inquiry where health visiting practices had been criticised (Vincent, Smith et al. 2007). In line with this focus, one of the key facilitators of the assessment tool's development was a child protection specialist and the name of the tool also focused on child concern over need. Almost all of the health visitors indicated some resistance to its use:

*CK: Okay, you mentioned a little bit back that you are increasingly feeling like the health police. What do you mean by that? What elements of your job, I suppose, make you feel that way?

*HV7: I think possibly the amount of box-ticking we have got to do and form-filling that we have to do now. It's still new, having to fill out the [assessment tool] paperwork and I have, since it came in, been showing it to the parents and saying, "We have to fill this form out, I have to complete this." And we are still not really awful certain what we are supposed to be doing. You know, I think as health visitors we are not awful certain what we are doing on that score.

In her subsequent response, the same health visitor reframed her use of the term 'health police' by establishing this role as a central aspect of health visiting practice over time. This positioning illustrates that a tension is evident where respondents resisted this area of their current work and accepted it as part of their practice, given there was the possibility of achieving an optimal professional environment for them to engage in this work:

Maybe I need to just retract that statement altogether because maybe before we used to be more the health police, you know, in the old days, you used to go and knock on doors, and you didn't always just have a purpose you were just there checking up. I think one of the good things, and there are lots of good things about the way we work now, is that you don't visit someone without a prior arrangement and you don't visit them without a reason, and without a discussed reason. You know, and

that is a good thing, like I have only mentioned negative stuff. You know, I think there are a lot of good things about the way that we are working, it has made us have to be much more open and much more, “This is the purpose of this visit and this is why I am coming.” You know, because there were a lot of visits done in the old days where you just happened to be visiting near Mrs. so and so and you hadn’t seen her for a while and so you knocked on the door. Now, that was awful and you know, we all know of health visitors who would just arrive unannounced and then one mother would get up and phone to another one and say, “So and so has just arrived,” and they would all pile in the car and clear off, to get away out of the area, because this was an old fashioned carbolic soap health visitor, [both laugh], and that happened within my day. (HV7)

She then contradicts this again later in her account by refocusing on health visiting work as inherently ‘policing’ work (Abbott and Sapsford 1990; Dingwall and Robinson 1993) and a historical aspect of health visiting practice, but which is executed within the context of contemporary work practices:

So, I think it is a good thing that there is more justification and more openness and there is more openness even if we thought we were being open in the old days, there is a lot more openness about the reasons why we are visiting, we don’t visits without a reason, in deprived areas where you are very worried about certain families, you do not visit without, you know, the reasons for it, and in some ways that makes that much easier. And you know, it is the way that it should be. Because it is their life and you are in their house and yes, you are policing the situation, really, but you are being much more open about it than in the old days. (HV7)

This example exemplifies the identity work (Rapley 2001) in which health visitors engaged in their interviews where they would work to construct themselves as ‘morally adequate’ through their professional practice with mothers being shaped by openness and integrity. This has similarities to how mothers worked to be seen as ‘morally adequate’ through their mothering practices discussed in Chapter 7.

The majority of health visitors suggested that working with vulnerable families is an established aspect of their practice, which they now respond to differently. There were a number of factors which health visitors attributed this to, including, most directly, that there are now substantially fewer health visitors than in previous years, and, in some areas an increasing population of families with young children, for example, through a recent increase in migrant families in some locations. More broadly, however, the majority of the

health visitors spoke about a service now driven by child protection work where health visitors are experiencing the pressures of a policy-driven imperative to work with children and families, who are often resistant to the work, to fulfil statutory child protection requirements. This shift, health visitors suggested, sharply contrasted with their previous practice of working with children and families where child protection concerns were generated through working with **all** families through the pre-Hall 4 child health programme. In conjunction, almost all of the health visitors spoke about experiencing an escalating sense of fear that their practice will be scrutinised and they will be penalised for events in families which have not come to their attention through the lack of opportunity for them as health visitors to engage these families in health visiting work:

*CK: ... I am just trying to get my head around why there is less time. You say it is to do with the corporate case load and the different clinics?

*HV1: Well, because there are not so many health visitors around, so there are fewer of us covering what was always there, plus, these extra clinics and things, well, contacts, and you know, you have to concentrate on the vulnerable families and things, you have to make these contacts, whether you know in your heart of hearts, you are going to make no difference what so ever. I mean, you can but try.

... these days, I mean it is going to end up that there is only going to be one health visitor per population, so many in the population, and they will probably be so busy doing child protection and the vulnerable families, that the normal people will have got lost well and truly. And that will get hived off you see,

*CK: the child protection?

*HV1: Well, the child protection because that is the bit that we hate the most, we'll keep that.

*CK: [laughs]

*HV1: No, it is true, you speak to health visitors and most of us enjoy the health promotion, we enjoy parent, you know teaching parents skills and things like that. Our original job was the promotion of health and the prevention of ill health.

*CK: Yeah, yeah,

*HV1: And basically, you could work within that framework, that is not the framework any more. It is: don't get caught by the police or the media, and make sure that all your drug addicts lock everything up. I'm sorry, I'm going a bit over the top.

*CK: No, it is interesting.

*HV1: Well, I don't think it is [over the top], because I worked with drug addicts at [name of area] for donkey's years, and we never had the problems, so.

The health visitors' accounts suggested that it is how their work practices are shaped, influenced and perceived by themselves and others which has changed rather than the complexity and nature of the social problems currently being experienced by families.

8.2 Health visitors' resistance

The health visitors' accounts suggest a number of forms of resistance from within the health visiting profession as their work becomes increasingly defined through child protection work which draws predominantly on a singular risk-orientated view of vulnerability. First, a majority of health visitors emphasised that in their view, vulnerability was something which could be experienced by all children and their families:

... it depends what you class as vulnerable, and, again, in this, with this clientele, the vulnerability comes with isolation and having high expectations in a situation that we can't easily manage, and the knock-on is usually a high level of anxiety, emotional depression kind of issues, which will have a knock-on effect to the child, but that isn't going to be actually seen as vulnerable, vulnerable usually comes with multi-agency working, when you have got quite clear things with drugs, alcohol, mental health, mm, special needs children, or parents with, you know, physical needs as well. (HV2)

While this was the case, the practicalities of their present experience told them that it was unlikely that these vulnerabilities would be recognised or resourced:

*CK: And in these situations where people maybe are very isolated, or they have mental health conditions, as a health visitor, what do you feel that you can do to mobilise things in order to support them, or to ensure that they can move to the place that you are looking for?

*HV1: Well, again, it so depends on the individual circumstances, you know, you can walk into one family where antenatally you picked up that you know, she has got MS, say, a physical problem, so you have organised home helps and she is on her own, so you have got home helps you have hopefully discussed with the children's centre this is a possibility, you have talked to social work and said this lady is going to need additional support, so you know, you have got everybody waiting in the wings. But the reality is that you know there is probably no place at the children's centre for under 1s. They are short staffed so they can't do any outreach work, social work say, "Well, there is no child protection worries there, so, you know, we can't help you." And the home helps say, "Well, you know, she has got enough money coming in, she will have to pay." (HV1)

Health visitors themselves spoke about how this broader view of vulnerability was often silenced through a public policy discourse which emphasised that resources should be directed to those deemed in need through risk (and perceived social justice) orientated agendas:

Well, I suppose if you are looking at Hall 4, they are saying that the concentration should be on the families with most need, so therefore that is implying that you should work with these families. But I would have said in a practice like this that families are not necessarily needy, but they do have lots of need, so you might be working with families who haven't gone down that road where there are a lot of people involved, it might just be maybe you, the GP, I don't know, maybe Homestart, and the children and family centre, so it wouldn't be as big as that, as wide as that, because we are supporting the family and it has not got as far as child protection issues, so, and I mean especially because we have a lot of postnatal depression here so, I mean you can do a lot of work with these families just in the way, sort of watchful waiting and supporting. (HV6)

... you feel guilty that you have not got the actual time to support these struggling breastfeeding mothers who are having a lot of the common difficulties that they have in the early days, and I think that, to me, is a rationalization issue where it's seen to be a wealthier, educated area and the resources are needed for somewhere where the problems are so much bigger. They are needed for child protection and for just to get a hold of people in another area and for other things. But it very much is an issue that a lot of these women can become pretty postnatally depressed, because they feel the pressures on themselves, they are maybe older professional women who are totally in control of their lives and suddenly things are all out of control ... (HV7)

A second way many of the health visitors challenged dominant discourse was through differentiating their profession from social workers who they suggested were positioned differently in their work with vulnerable families. Many of the health visitors appealed to the concept of universality and applied it to health visiting to articulate this. As well as speaking about vulnerability as potentially universal, the health visitors spoke about their profession as having a universal remit to work with all families. The majority of health visitors' accounts suggest that they feel that the universal remit of health visiting is central to both their practice with children and families and to their professional status. It is this aspect of their profession, they suggest, that allows them to work with some families more than others, through the normalizing effect of working with all families. In line with this, the

health visitors spoke about the unspoken limitations this placed on their practice (and which they themselves placed on their practice) in order to preserve this way of working:

We have been questioning it [the assessment tool driven by child protection agendas], and there is a lot of it that I feel we don't have a right to ask, and I know it is a guidance about some of the things, and like, does the child sleep in clean bedding and things, we don't have a right to walk into someone's bedroom, we don't have a right to be in their house, but as health visitors we are one of the few people who have the ability to knock on someone's door because, well, people from outside Britain might not know what we do, as I said earlier on, but they are kind of half expecting to see the health visitor, so we are allowed over the front door, but we can't say, "Well, can I just check your bedrooms whilst we are in?" (HV9)

I think well generally, because you know, everybody has heard of health visitors, you know, it's non-threatening, it's non-statutory, you know, don't have any power, whether you have got a substance misuse problem or not, everybody has got a health visitor, so people generally feel quite, you know, friendly health people kind of thing, and they, I mean, there is always a power imbalance because you are wanting to see them, you know what I mean, it is your agenda, but there is less of a power imbalance than with some of the other statutory agencies involved, and that is a good place, or a better place to work with families from, than this, if you don't then we will take your kids off you, which is essentially what they are saying, in lots of wrapped up ways, but you know, that is it ... whether you like it or not. So, I much prefer, they say that vulnerable families, people who work with vulnerable families and do we do a lot of child protection in the health visiting service, that, over time, especially given the community health nurse review ... [unclear reference in audio recording to social work] ... not if I can flipping help it. You know what I mean? That is not where I am from, you know I am health, health, and I came into health visiting because I was interested in public health. Where did that go? You know what I mean? So, mm, and people are people and some people are easier to work with than others, but generally because of the universality of health visiting people are happy to work with you. (HV16)

The majority of health visitors also differentiated more substantively from the work of the social work profession which they saw as focusing on ameliorating the effects of inequality, neglect and abuse, and which they demarcated from their own profession which they constructed as (ideally) a universal service to meet the health needs of all children and families:

I think we are still very fortunate that they don't see us as attached to the social work department. They very clearly see us as very different from the social work department, although I have to say that nowadays there is so much more social monitoring being done by health visitors because there isn't an allocated social

worker that for us professionally, I think I can say it is blurred as to whether we are searching for health needs, or whether we are actually child protection monitoring. Because I don't think it is as blurred for parents in that they do see us in a health role and an enabling role. But [emphasises] that depends on their relationship with the health visitor. (HV8)

*CK: And in terms of Hall 4, that has painted a useful picture. Are there any benefits as you see it of working in this way?

*HV4: Well, I would say that the, I suppose the intense visiting of the vulnerable families is useful. It depends if you have got enough staff on the ground, because I have currently got 27 families who are family in need records, those are the families, not the number of children, and it is too much for one person, because if you are aiming to visit them at least once a month, and often there is a lot to do with those families in the way of referral on, supporting, making sure you are accessing the children, following things up, there is an amazing amount of work to do with them. So that can take a lot of time, so it is very time consuming. So it has taken up the time from having done the development checks, I mean more than, because we are going into things in much more detail perhaps than we did before, but again it is trying to keep the health emphasis and not be sucked into the social side, social work side of things, and I think that is quite difficult.

*CK: Okay.

*HV4: Because we are not the health police, but we have in fact become the health police. It is like policing these families.

A few of the health visitors also drew other comparisons where they felt that with the increasing emphasis in their work which drew it closer to social work also distanced it from what had previously been their remit around health promotion and parenting work. This work with children and families they felt had been marginalised in health visiting practice and claimed by early years programmes but with an expectation that health visiting expertise would still be available. In this way they worked to show how their everyday observational and relationship work with families had all but disappeared:

And it's sad because I think that we're getting really focused into child protection, which we're all involved in, you know, but none of us want to be social workers ... it's like a role we're getting sort of pushed into. ... We're supposed to be dealing with the normal children. And all these things we're talking about, that's what we're supposed to be doing. ... the health promotion which health visitors used to do. Like the preventative, we used to go and talk to groups which you can't do now. So from something that was universal and hit a lot of boxes which highlighted things. We've been gnawed and gnawed and we're not using our skills to the best that we could use them.

*CK: ... in a utopian world, what would you like to see more of, what do you see as a good health visiting service... ?

*HV14: ...you see people ... maybe reintroduce the two-years check. ... To get out and talk about your healthy lifestyles. Which is all the things we used to do. For us to do the – they have like early years programmes and stuff like that, and this is what we mean, we have these groups and you get the groups and the – and they have great coordinators or facilitators and technically the bottom line is the health visitor teams are going to be doing the work.

In this way, the health visitors worked, through their accounts, to (re)claim the territory upon which they have developed and maintained their expertise and professional status as health visitors over many years.

8.3 Professional vulnerability

Ironically, for the majority of the health visitors, the corollary of the changes to their practice was a professional vulnerability from which they experienced very real manifestations in their personal lives, for example, lack of motivation, physical symptoms and mental distress. While health visitors felt that child protection work had always been an aspect of their practice, they felt that the requirements placed upon them (and the personal pressures this brought) to evidence their practice with families had increased. Many of the health visitors used language with a legal/defensive tone where they spoke about feeling the need for a ‘safety net’, in this ‘day and age’, and feeling they were being ‘defensive’ in their practice. In doing this they expressed their frustrations at a practice where they felt that they themselves were being monitored and required to document their practice. This said, their accounts suggested that this was not necessarily experienced as an entirely negative practice development:

And it is quite good to be able to document, because at present you feel kind of, I suppose quite vulnerable, that you are supposed to decide what these families are and there is nothing written down, so if we have this as a written piece of work, to say, right, at this time, this family were fine, I suppose if in 6 months’ time, or a year’s time somebody says, “What has happened?”, I can say, “Well, actually, at that time they were fine and I put them onto Core.” So I think it is kind of, it sounds awful, but a kind of safety net for you as a practitioner I think, in this day and age. (HV3)

*HV12: There was nothing in black and white before so this [the assessment tool] is a wee bit more kind of robust framework that we've got to use.

*CK: And what's your professional take on it? Do you find it helpful or useful?

*HV12: Yeah, I do. I just think in this day and age now and the way things are I think we do need to have quite robust assessment tools to use. We shouldn't have to, but it's to justify what we're doing and how we've come to the decision that this family are going on such and such a level of care, and I think we do have to have the evidence to justify that.

I think filling the paper in is the problem, actually the assessment part of it, is okay ... but when you are busy, it is just another piece of paper. ... I think as a sheet of paper, once we have got it, it is going to be supportive to practice, especially with core families, you know, because if they are a core family, they may notionally not ever get seen again by a health visitor. So, we need to have something that says that when we saw them we thought it was okay to make them core based on this information and that maybe sounds defensive, but I think it is the tool that we have got. (HV10)

The majority of health visitors, while welcoming the reassurance written evidence of their practice gave them, also spoke about it as problematic in relation to how they worked with families. The tensions inherent in their practice with families where they sought to support and enable families in their care of their children and to protect themselves within their professional practice are evident in this extract from Health Visitor 6. The extract is necessarily long to show how in her expressions of going 'full circle' she carefully traverses a number of other issues underpinning and shaping health visiting. She tentatively positions her practice around professional judgement as both subjective 'you would be putting down your judgment' and objective 'you are just stating the facts'. Later, she expands on this when she says 'most of it was in your head, as you do, you make your judgements as you go' which she then works to make objective again by adding the word 'clinical' when she says 'you make your clinical judgements':

*CK: And is the [assessment tool], is that something that you have been using for a while now?

*HV6: It just started a couple of months ago. It is a case of things going full circle because we used to have records where we wrote everything down, the records changed, and we were actively discouraged from writing anything down unless it was a problem. So, we have records with very little. All we have is developmental checks in them and nothing else if there is no other problems. And now it has come back full circle because now we are having to, well, as we have always done is make

judgements about families, but, where is the evidence for that, so they have brought back in the [assessment tool]. But I feel that we have just gone full circle.

*CK: And what is your experience of using it so far?

*HV6: I think it is quite hard because everything that we write down has to be shared with the family, so you know, you have to, whatever you put down has to be read by the families, so that has to be couched in terms that are not going to cause offence when the families actually see that. So, sometimes just writing down very general things like good home environment, comfortable, well-heated, you know, baby adequately clothed, breastfeeding, that kind of thing, are fairly bald statements.

*CK: Right. And do you feel that it gives you the opportunity as a professional to draw on your judgment, is there scope to do that within the framework if you like?

*HV6: Well, yes, because you would be putting down your judgement about their parenting skills and how they were looking after that baby, and if there were any concerns in that, if the baby wasn't being fed, or if the environment wasn't very good. Or, you know, it feels sort of dirty, or they are drug users, well, yes, you would have the opportunity to write that. And I suppose all you are doing is stating facts. It is not asking for opinion, you are just stating facts about what you find.

*CK: Right. And how do you feel about coming full circle. Do you think we have come to a good place?

*HV6: No, I just feel that we have gone back full circle, because, well I think it is quite nice to have an opportunity to write down things because I think that was lacking in the past, and although we had on the computer system, the CIS system, you could write comments it was limited to the number of characters that you could use, so you quickly ran out of space if you wanted to write a lot. So, with this you can write as much or as little as you want. And the idea is that you use that over a 3 to 4 month period to build up a picture of a family, it is not just a one-off, it is a sort of ongoing assessment, and at that end of that time, you will decide, you know, what their needs are. And obviously, you will have been doing that all along, but at the end of that you will make a judgement about what is happening and what kind of service you are going to offer this family. So, in that respect, yes, it is a useful tool, because if somebody says, "Well, how did you arrive at that assessment?", you can say, "Well, there's my evidence," so before that wasn't so easy to do because most of it was *in your head*, as you do, you make your judgements as you go, you make your clinical judgements as you go along, so we have now got the evidence to back that up.

The process of holding information in 'our heads' talked about by the health visitors 6 and 7 (above and below) suggests a shift where professional judgement and the thinking processes with which health visitors engaged were held to be the core value of professional practice to a focus on objective assessment which is documented and can be used in response to the 'incalculable insecurities' (Beck 1992) of modern life:

*CK: Yes. And so what does a relationship look like when it is at its best? When it is really ticking along ideally? What are the characteristics, if you like?

*HV7: I think if we know a bit about them and their background and their coping skills and their supports and things and that is part of the continuous assessment I, that you are doing of the set up. And with Hall 4 now, we are having to document that, whereas before, we would have that *in our heads*. And that they are aware of services, and they are aware of us and what we are like, and I think approachable. And it may be that they don't want us at all, you know, they definitely don't want our service, but they know that they can come and go, and they can dip into service and out again if something crops up. And we have always done that, but it is so much more important now with Hall 4.

Resistance to their work being framed through an emphasis on child protection/risk presented itself in a number of ways in the health visitors' accounts. This included their articulations of alternative forms of vulnerability. Another form of resistance was evident in how health visitors constructed their knowledge of families for other audiences. Many of the health visitors took on a guardian role of families where they took measures to protect the children and families from the harshness with which their lives were perceived through the child protection agenda where they worked to reduce the (potential) stigmatizing effects of the judgements they were making (being asked to make) through their professional work as health visitors:

... this [assessment tool] gives you more scope to write, there is more scope to write things if there are issues, and you can then identify definitely core, additional or intensive, so from that point of view, I suppose that is nice, I think the form just needs to be clarified. I mean, yes, I am happy to share anything with the parents, I would always share the child health surveillance thing and they would get a copy anyway, but it also seems an incredible value judgement to be putting, you know home circumstances or social issues on that, say it is a first visit to a family, I think that is quite difficult. A bit like when the computer printed out "drug-abusing family". Well, I don't want that going on any form for a mother. You know, you might put "social issues". But you don't, you know, there are ways and means of writing things that are not going to be offensive to parents, because then you just do set up barriers I think, you have got to be very careful with your terminology and the way you word things. (HV4)

The majority of health visitors suggest tenacity in their practice. Their accounts and some (although not all) policy papers suggest that they are working 'against the tide' in their efforts to maintain a universal service as the basis for targeting to meet the needs of the most vulnerable families with whom they work. Most of their accounts suggest, however, that

despite these efforts on the behalf of the children and families with whom they work, they are finding it increasingly challenging or impossible to practice with a universal remit. They are finding it necessary to protect their professional practice from criticism and that the structural changes to their profession are making a universal remit no longer an achievable goal. This difficulty was expressed by the majority of health visitors and often with a palpable frustration in their voice through their comments on increasing numbers in their caseloads and decreasing numbers of health visitors:

*CK: ...you said about needs assessment, about the [assessment tool], and from the expression on your face ...

*HV8: laughs. I mean I can see why it's been brought in and I absolutely agree with it as a tool. But, just as – pause – I think in all professional groups we are now getting straight jacketed for the “what if” situations, and there is less and less room for clinical judgement and my feeling now is, and this is shared by a lot of my colleagues, is, that you are perfectly willing and happy to make clinical and professional judgements, so long as they are the right ones, and families are dynamic and moving and shifting all the time, and what you do, you won't find another colleague doing exactly the same, and it's all to do with the history and all the nuance that is unspoken. And so this model is, I feel, is a response to, saying if anything goes wrong, oh, oh, we didn't do a proper assessment there. And the whole thing is flawed from the outset because what it assumes is that there is sufficient time to do a robust assessment. And there isn't. So, I absolutely appreciate and agree with the thought that there should be a robust assessment, but nobody is actually brave enough to say that this is not possible.

... if our case load has increased by 400% then has health visiting hours increased by 400%? – have they heck. So, if you are looking at it from time-wise point of view, if you have got all of these notifications, then at least 4 contacts, and all of these immunisations, not to mention, DNAs [Did Not Attend for appointment], can we change, baby is not well, we are going swimming, we are on holiday, nah, nah, nah, nah, is it physically possible to actually do it? And put in I have got 7 weeks' annual leave as well. So 7 weeks I am on my own with this huge caseload, and then we have got sickness, and mandatory training. And, we are continually being skill mixed, but the only person that can do any of this is 'us'. At some time somebody has got to be collectively brave enough to say, 'This is not possible'. (HV8)

More and more the child protection side of things is shadowing. At the moment we have not only our own caseload that we are covering, but we work in clusters, so that there is ourselves and we have [name of other surgeries] in our cluster, so if [other surgeries] are short-staffed we try and help take up the slack. And at the moment, a colleague left last week so we have taken some FIN files from [name of practice] only a couple, but that is the kind of thing, at one stage we had taken some

from [name of surgery] so there is the implication that wherever there is a concentration of health visitors they will be moved, or they will take on these files. So that changes the balance of your case load as well. (HV1)

While health visitors suggested that holding onto a universal service and knowledge of their caseloads was important to them in their professional practice they at the same time expressed frustration at this not being feasible with the resources available to them. Their accounts suggest that their practice and demarcated professional ground constructed through a focus on health and working with all families is gradually diminishing:

I think because I don't know my case load as well as I should because I don't have the regular contact, as I say to you, I assume everybody in these bottom three drawers is fine [of filing cabinet] or the bottom two drawers because you are concentrating on the top one and everyone you are just hoping is okay, so, I feel you are missing out on that. I mean I know that 99% of the children you see are fine anyway, and people say it is a waste of time doing the screening, but it is still about the contact and particularly 2-year checks, mums would often have queries, or temper tantrums, or sleepless nights, potty training or something, and they don't come to you with that any more because they don't see you. (HV3)

This was emphasised by health visitors in their accounts who would return time and again to articulate their resistance to the loss of a universal service:

I think, to be quite honest, I don't know if I would manage all the check-ups if I was still doing them, with being on my own with the case load you know, with the kind of case load that I have got. It would be quite difficult. Is it a benefit? I don't know. Is it a benefit to the kids? I don't know. [Pauses]. I would probably say no then. Well, for practitioners, I would probably say no, because you miss the contact with children, you miss, you will get mums phoning up and saying, "Can you remember me?" And I will say, "Of course I can remember you," I might not have seen them for a couple of years, but I still know who they are ... (HV3)

A few of the health visitors interviewed took a different perspective from the majority by suggesting that child protection work was and should be the focus of their practice. These health visitors equally, however, expressed difficulties and tensions that they experienced in achieving this in practice:

*HV10: I suppose I am quite clear now that my role is about protecting children. Supporting families, but protecting children.

*CK: And that is something from the initial days that you ...

*HV10: No, I did my level 3 child protection training, and I think that helped to clarify that point for me. I think that whilst I did that, you know, when you are looking at the Children's Act, and protecting children, vulnerability factors, and what helps resilience, and what protects children. And human rights, children's rights, you have got all these thousands of rights, but at the end of the day, everybody cannot, you can't be equal. If you are going to protect children then there comes a time when maybe the parental rights, you can't, everybody cannot be equal, and I suppose the children are the vulnerable ones. You know, if I dealt with the older people, I would feel the same about the older people, my job at the moment doesn't really involve working with the elderly. Basically anybody that is vulnerable.

*CK: So, that is interesting, basically there was quite a professional shift in terms of how you dealt with child protection issues, I suppose between, through doing that course?

*HV10: I think it really just gives you time to think about what you are doing and why you are doing it. But, I do think that when you are protecting children, you have got to look at the family. The whole family. And you have got to work with the whole family. You can't parcel people off. Putting even different children in compartments doesn't support a family. You have got to look at who lives under that roof.

Despite the greater openness of these health visitors to child protection work being the focus of their practice, they expressed similar concerns about their practice being limited by and through this child protection focus:

*CK: Do you find, you are probably in a good position to reflect on this really, because a lot of your work is with vulnerable families, do you find that because of that you have the opportunity to work more effectively?

*HV10: Nah, there is a lot of monitoring goes on. Hmm, there is [emphasises] a lot of monitoring goes on ...

The health visitors' accounts suggest that with the loss of a universal focus to their work, opportunities to work with 'vulnerable families' has also diminished.

8.4 Discussion

The health visitors' accounts suggest that they view their work with vulnerable families as an established aspect of health visiting practice. Their accounts suggest that a dominant discourse of vulnerability as 'risk', expressed through their increasing involvement in monitoring and policing families and in statutory child protection work, increasingly dominates their practice. At the same time they are experiencing structural and resource

changes to their profession which impact on their practice. By drawing on their health visiting practice in the past, for example, health promotion and parenting work with families, they work to demonstrate how their practice in protecting children was borne out of their knowledge of individual families within communities (Smith 2004), over being conceptualized through dominant and medicalised modes of thought around public health work.

The research findings suggest that the health visitors are trying to hold on to professional territory by making claims to the universal nature of vulnerability and through which knowledge and expertise is health focused and, hence, differentiated from other professional groups, for example, social workers. The health visitors' response to the increasing dominance on vulnerability discourse around risk which disregards their experience has similarities to what Ceci (2003) refers to as 'midnight reckonings'. This is where health visitors are able to be both rational practitioners, maintaining a coherent self, and at the same time to have grave doubts over the direction of travel of health visiting practice. This is driven by a strident child protection agenda conflicting with their practice which has been established over time through knowledge and experience of working with all families over time.

The dearth of literature on child protection and health visiting over the last two decades has been commented upon (Cowley, Mitcheson et al. 2004) and is a puzzling gap in the literature. Cowley and colleagues (2004) suggest that this gap may reflect a commonly held view that child protection work is the work of social workers and social services, and not health visitors and health services. What the findings of this research suggests, more likely, however, is that health visitors' experiences of changes to their work with vulnerable families and the dominant discourses around child protection have simply filled the vacuum left as health visiting experiences ongoing challenges as a profession. Dingwall (2010), in his recent essays on the professions, draws on his PhD work from the 1970s which focused around health visiting training and how health visitors 'accomplish profession' through comparison with other profession groups, for example, doctors and social workers. One aspect of this construction was to establish their own area of expertise as different and

'better than' these other groups. The findings from the research reported in this thesis suggest that, for health visitors, some of their expertise, premised on knowledge of child health and development and through working with all families, has been lost. Its natural succession has not been more time to work with the most vulnerable families, but rather a profession which feels it is now engaged in a struggle to hold onto its differentiated territory of professional expertise.

In Chapters 5 to 8 I have discussed the findings of this thesis. I turn now, in Chapter 9, to explore the findings in relation to theory to consider their implications for health visiting practice, the profession, and for the children and families with whom they work.

9.0 Introduction

In this thesis I have argued that the implementation of Hall 4 has impacted on the health visiting profession, and the children and families with whom they work, in diverse ways. In this final chapter I explore what the findings of this thesis can contribute to theoretical understandings before considering the policy and practice implications of this study. First, in section 9.1, I explore how normality has largely been replaced by risk in both early years policy and health visiting practice. At this point I shift to use, as my benchmark, theoretical thinking which has been developed within the context of social work practice (Ferguson 1997; Parton 1998; Ferguson 2001). I take up Beck's concept of 'cultural symbolism' to explore why child protection has become a focus of health visiting practice. I then problematise this model through considering the implications of a focus on risk in early years policy and health visiting practice for all families with young children, and in particular, those who are defined and categorized as 'vulnerable'. In section 9.2 I bring in the work of Ahmed (2004) around collective feelings to take a new look at the observational and relationships work that health visitors talked about in their interviews. I consider how the risk agenda translates in health visiting practice with children and their families. Having considered how risk has shaped contemporary health visiting practice, I move in section 9.3 to look at a parallel development which is the emphasis on evidence-based practice in the health professions. I consider the implications of this development for health visiting practice, for the profession as a whole, and for the children and families with whom they work.

In section 9.4 I consider what these dual emphases on risk and evidence-base mean for health visiting as a profession. I consider the shape that health visiting was in prior to Hall 4 before suggesting, tentatively, where health visiting might be now as a profession in its aftermath. To do this I draw on Dingwall's (1977) 'accomplishing profession', Lipsky's (1980, 2010) 'street-level bureaucracy', and Powell and Gilbert's (2007) work exploring the caring professions using Butler's concept of performativity. I suggest that the insight gained

from social work, ironically, the profession which health visitors worked the most to differentiate themselves from in their accounts, can provide pointers as to how risk has become embedded within health visiting practice and how the profession could use this to its advantage in its professional work with children and their families.

In section 9.5 I consider methodological issues emerging from this study and consider their implications for future research. Finally, in section 9.6, I return to where the study began; policy and practice. I consider the broad question – what does this thesis and its findings mean for health visiting practice and children and their families in Scotland? The opportunity to consider this question is timely, as ‘A New Look at Hall 4 – the Early Years – Good Health for Every Child’ (Scottish Government 2011c) and the (draft) guidance for the introduction of a 24-30-month child health review for all children in Scotland (Scottish Government 2012a) have recently been published. I make my concluding remarks to the thesis in section 9.7.

9.1 Overview of the thesis

To recap, the overall aim of this study was to explore how health visiting and mothering practices have been shaped by the implementation of Health for All Children (Hall). Hall 4, published in 2003, marked a shift towards a more targeted approach to service provision, predominantly through the work of health visitors, yet aimed at meeting the needs of all families with young children. In Chapter 2, I explored how risk has become a central aspect of policy around the early years. The existing literature, explored in Chapter 3, analysed health visitors’ role in the implementation of Hall and suggested a cyclical and challenging relationship between developing an evidence-base and the health visiting profession. In Chapter 4, I explored how researching a topic of policy and practice relevance produced a specific and localized set of ethical dilemmas. The foregrounding of my analysis of the health visitors’ and mothers’ accounts provided analytical and conceptual insights into the implementation of Hall 4 in practice. In Chapter 5, through exploring the accounts of the health visitors, a stark picture began to reveal itself of a profession whose practices have been challenged by the new policy context framed by Hall 4 and wider policy around the early years. In Chapter 6 an exploration of health visiting practice revealed the

observational and relational aspects of health visiting practice. I explored the role of judgement in health visiting practice and tentatively considered how health visitors work to construct 'vulnerability' through their practice. Chapter 7 focused on mothers' experiences of caring for the health and welfare of their children where, by paying careful attention to the emotion in mothers' accounts, we saw how all mothers can experience vulnerability when caring for young children. My final findings chapter (Chapter 8) brought the thesis full circle by focusing on how health visitors both accept and resist the risk discourses that shape their work with children and their families. Health visitors did this by offering alternative views of vulnerability, differentiating their work from social work and by returning to their professional roots in nursing and public health. In this chapter I now consider the contribution to knowledge which these findings make using existing theory.

9.2 From normality to risk

The study findings suggest that health visitors construct their pre-Hall 4 work through a focus on normality. Their knowledge and expertise of child development is generated through working with a majority of children over time. Their role in this process is the identification of children whose development is differentiated through using the concept of normality. Normality is conceptualised by the health visitors through iterative processes which draw on their knowledge and expertise generated through experience and learning.

In differentiating their practice (between then and now, pre- and post-Hall 4) health visitors draw on normality and differentiate it from risk. They construct risk through their practice, for example, through the prioritisation of child protection work and the perception that their role increasingly mirrors that of social work. They locate normality as dominant in their practice 'then' and risk as dominant 'now'. Concepts of normality, however, can only be understood in relation to the notion of expertise which is moral and involves judgement (Rose 1990). As elaborated in Chapter 3, the notion of normality is well demonstrated through Armstrong's (1995:397) use of the familiar imagery relating to the monitoring of height and growth.

The prominence of the practice of weighing in both health visitors' and mothers' accounts illustrates the extent to which notions of normality have become embedded in everyday practice around child health. This suggests that the shift to risk, although present, has not completely usurped ideas about normality and normal development. However, the study findings suggest, that notions of normality, although not replaced, have shifted. As both Armstrong (1995) and Rose (2001) highlight, the disciplinary machinery of surveillance has incorporated risk discourses where the monitoring of 'precarious normality delineates a new temporalised risk identity' (Armstrong 1995:403). Pre-Hall 4 the concept of normality dominated practice. Health visitors' accounts suggest that risk now (post-Hall 4) defines their practice. Thus, risk and normality both connect through and shape health visiting practice. This new landscape has implications for how vulnerability is understood and for all children and their families, a premise which I will now discuss.

Ferguson (1997:229), in his conceptualisation of risk in relation to child protection in social work practice, discussed in Chapter 3, suggests that reflexive modernisation has led to a situation where the failure to protect children is attributed to the workings of the system which has been set up with this aim as its primary goal, that is to say, to protect children. Increasingly, the health visitors' accounts suggest that health visiting has become part of this discourse. The focus of their work on children and their families, now, almost solely, is perhaps a key element of this dialogue. Central to Beck's theoretical thinking on risk, Lupton (1999:61) highlights, is 'cultural disposition' where he questions why some phenomenon are given importance, while others are not, for example, why dying forests are, while hazards on roads are not. The reason, he suggests, is our understandings of risk where our responses are:

... symbolically mediated. Symbols that touch a cultural nerve and cause alarm, shattering and making incomprehensible the unreality and hyperreality of hazards in everyday life (Beck, 1995: 47: cited by Lupton 1999:62).

In this way, the child, who is understood as 'precious but burdensome' (Mayall 2002) and who is positioned within social roles which are subordinated and protected, becomes a symbol. A child's death, when attributed to the negligence or acts of man, for example,

those of health visitors and/or social workers and/or parents, comes to ‘stand for the vastness of risks that surround us, rendering comprehensible the incomprehensible and giving us a target on which to fix an illusory sense of control’ (Lupton 1999:62). This is particularly true for mothers who are constructed as the main protectors of children (Davies and Krane 2006). Where parents have failed in their role as protectors, others must be responsible, and so health visitors and social workers become these ‘targets’.

Lupton (1999), in her work on risk, also draws to our attention to the Foucauldian perspective where ‘expert knowledge’ is central to governmentality. It is an aspect of how populations are monitored and surveillance made of them. A network of actors (including health visitors) and technologies govern risk, collecting, monitoring, and analysing data about risk:

... through these never ceasing efforts, risk is problematised, rendered calculable and governable. So too, ... particular social groups or populations are identified as “at risk” or “high risk”, requiring particular forms of knowledge and intervention (Lupton, 1999:87)

This perspective affects everyone in the population as the responsibility for risk is transferred back to individuals and how they should live their lives. Hence, risk becomes a central constituent in constructions of the ‘good’, ‘good enough’ and ‘perfect’ mother – a benchmark against which mothers are judged and judge themselves (Murphy 1999; Wall 2001; Marshall, Godfrey et al. 2007). In this way, Lupton (1999:88) highlights that risk affects everyone, those deemed to be ‘at risk’ or ‘risky’ and those who are not. The tension in the health visitors’ accounts between acceptance, prioritisation, and, at the same time, resistance to the focus of their work practices being shaped by concepts of risk, then is not surprising. This is particularly the case given that, as Murphy (2003:458) highlights, ‘health visitors do not themselves stand in a position of exteriority to ... dominant discourses ... Rather, they like mothers are caught up in the disciplinary technologies to which they contribute’ (Murphy 2003).

Further to this Foucauldian perspective, Castels (1991) suggests that there has been a shift from ‘dangerousness to risk’ (cited by Lupton 1999: 93). Concern has shifted from individuals being dangerous to the possibilities of undesirable events generated through the

assessments of ‘experts’ and which could be prevented with early intervention (Peterson and Wilkinson 2008:7). Risk for individuals, rather than being directly observable, is about being in a web of risk where individuals can do little to change the shape of the mesh. As Lupton suggests:

To be designated “at risk” is to be located within a network of factors drawn from the observation of others, to be designated as part of a “risk population” (Lupton 1999:93).

This observation reflects a shift where the ‘risky’ individual may not need to be present or observed for:

... signs of dangerousness. It is enough that she or he is identified as a member of a “risky population”, based on a “risk profile” developed from calculations using demographic and other characteristics (Lupton 1999:93).

Health Visitor 3’s comment that ‘the Intensives’²⁴ tend to stay Intensives’ was evidence of this shift in attitude. For individual ‘vulnerable’ families, the downward pull of being understood as ‘vulnerable’ has a self-fulfilling potential. While, for many other mothers, the majority who are not deemed to be ‘vulnerable’ or part of a ‘risky population’, seeking and accessing support can become equally difficult.

Risk, this suggests, is also political. Hall 4 has been contextualised in terms of resources from its inception. It is only in the later text of the Hall 4 report, however, on Page 345 that this becomes evident:

... when resources are limited and skilled professionals are in short supply, it is unquestionably important to minimise routine tasks, whose benefits are uncertain, in order to release time and energy for children with higher levels of need (Hall and Elliman 2006:345).

In conjunction, the focus on risk in contemporary policy requires exploration in relation to political consequence where a focus on the prevention of infant deaths where children are known to be ‘at risk’ can be at the cost of investment in social and educational environments for all children, which, the work of epidemiologist Geoffrey Rose would suggest, could have

²⁴ ‘Intensives’ is a reference to the Health Plan Indicators system of categorising used by health visitors (Scottish Executive, 2005) discussed in Chapter 2. Children and their families categorised with an Intensive HPI are also widely described in policy and practice communities as ‘vulnerable families’.

a greater impact on population health and well-being (Rose 2001: reiteration, first published 1985). The hierarchy of evidence (and tools used to generate it) propagated through evidence-based movements, also goes some way to explain the dissonance which health visitors articulated between experiencing their practice as effective and witnessing this and their effectiveness being validated by others, or indeed, by themselves.

The accounts of health visitors, and mothers themselves, in this study indicate the possibility of alternative concepts of vulnerability to those shaped by a discourse on risk where vulnerability can be experienced by any child, parent or family. Health visitors used these perceptions in their accounts to resist more dominant conceptualisations, and they were also revealed in mothers' accounts through close attention to the emotion in their accounts of caring for their children, for example, through their interactions with health professionals when their child was unwell or had had an accident. Even when families are deemed 'vulnerable' through other discourses, however, it is likely, as the experiences of the health visitors and mothers in this study suggest, that they are not deemed vulnerable *enough* in light of diminished resources:

... the problems of rising demand set against fixed or diminishing resources, mean that the nature and level of need are increasingly (re)framed or rationed in terms of risk (Parton 1998:22).

This approach influences the direction of resources (and surveillance) which becomes focused mainly on those who are deemed vulnerable, at risk and 'risky'. This not only has implications for the 'vulnerable' families themselves, but for all families, and for the health visiting profession.

9.3 What the concept of risk means for health visiting practice

The disciplinary and gendered nature of health visiting practice has been documented (Wilson 2001; Peckover 2002a; Peckover 2002b). The findings of this study, reported in Chapter 6, where health visitors used photographic metaphors²⁵, for example, where they

²⁵ Understanding these metaphors can be assisted by imagining the process of taking a photograph of a landmark, for example, Edinburgh Castle. If the photograph is taken with the photographer's back to the Castle a photograph of Princes Street, full of shoppers, comes into view. In contrast, if the photograph is taken with the photographer pointing the camera towards Edinburgh Castle and the Castle itself becomes the 'snapshot'. Hence, two very different

talked about using ‘snapshots’ to build up the ‘whole picture’ of the circumstances of a child and their family and techniques of rapport and talk to elicit their ‘stories’ suggests that health visiting practice may play a fundamental role in identifying which particular ‘social groups or populations are identified as “at risk” or “high risk” ... ’ (Lupton, 1999:87). Ahmed (2004), through her exploration of emotion, its relationship with collective feelings, and subsequent role in distinguishing between the ‘inside and outside’, provides a useful theoretical lens through which to consider health visiting practice. Ahmed (2004: 29) in her work suggests that it is through our experience of emotion generated through our interactions with others that distinctions between inside and outside are formulated. The development of the surveillance of the health of the child and the responsibility of this being that of families, and in particular, mothers, which involved obligations around clothing, hygiene, physical activity and family relationships, has been well documented (Lupton, 1995: 26). The relationship between dirt, surveillance and marginality becomes particularly resonant here:

... the rituals of hygiene, directed at both the private body and the body politic, have remained vital in maintaining the distinction between spaces and bodies. On the inside of the boundary lies social order, “Us”, while on the outside is a twilight place of outcasts, danger and pollution (Armstrong 1993:394, cited by Lupton 1995:46).

When health visitors talked about, for example, ‘sticking to the carpet’ where ‘you can’t see the colour of it, there’s a pattern on it, but, you know, it’s just absolute filth’ (HV15), this, the work of Ahmed (2004) would suggest, was more than an observation of fact. They were observations that the health visitors became aware of (and processed) through a heightened awareness of the presence of their emotions. At the same time, references to ‘lodgers lying on a bare naked bed in the kitchen and a hot plate on, and a child sitting on the cooker next to the hot plate, or, you know, is there a pair of drug scales in the house?’ (HV7) conjure up images of danger where children’s health and welfare are potentially under threat. Ahmed (2004) suggests that:

... rather than seeing emotions as psychological dispositions, we need to consider how they work, in concrete and particular ways, to mediate the relationship between

‘snapshots’ are produced through the interactions between the same photographer, camera, and subject at (only slightly) different points in time.

the psychic and the social, and between the individual and the collective (Ahmed 2004:27).

Health visitors are told to observe for signs that a child may be at risk of harm. This is operationalised through contemporary policy on the early years and the tools which health visitors both accept and resist the use of in their practice. An example of this is the assessment tool, which had been developed and put into practice through concerns about child protection and professional practice, being used by participants in this study. The 'sticky carpets' and 'bare naked bed' are experienced as emotion, which bridges the gap between the individual observations of health visitors, and 'collective feelings' through which children and their parents, in particular their mothers, become judged. Ahmed (2004) warns us of the importance of this:

... how we feel about another – or a group of others – is not simply a matter of individual impressions that are created anew in the present. Rather, feelings rehearse associations that are already in place, in the way in which they “read” the proximity of others, at the same time as they establish the “truth” in the reading. The impressions we have of others, and the impressions left by others are shaped by histories that stick, at the same as they generate the surfaces and boundaries that allow bodies to appear in the present. The impressions left by others should impress us for sure; it is here on the skin surface that histories are made (Ahmed 2004:39).

The emotions which health visitors' experience through their work and shaped by a discourse of risk, then, can act powerfully to reinforce, or challenge, existing ideas of good parenting. The judgements that health visitors make in their practice go beyond observations of the individual family to draw on existing relationships between, for example, class, gender and parenting practices. These associations have been well established over time and can act powerfully in the marginalization of vulnerable families.

A further observation, present in the health visitors' accounts in this study, and related to this phenomenon, is that the focus on children (cultural disposition) and child protection in health visiting work increases when, for example, child death reviews occur and their practice is criticized. Despite evidence of their resistance to this work, it becomes an inevitable part of the fabric of what constitutes health visiting practice. This underlines, I would argue, the importance of reflexive health visiting practice which can make use of the

presence of ‘collective feelings’ to the benefit of, rather than to the detriment of, the children and families with whom they work.

Health visitors’ judgement is often articulated in the literature as an issue of profession, in particular, discretion and autonomy, where resistance to formula-based assessment tools is often expressed and seen as a form of medicalisation of health visiting work (Cowley, Mitcheson et al. 2004). An aspect less well-studied is the relationship between class and judgement in health visiting practice. There has been very little theorisation around class and health visiting practice at all. An exception to this is the work of Symonds (1991) who explores how class is propagated through health visiting practice itself rather than being an ascribed category. Lawler (2005) explores the relationship between dirt, class and mothering practices and how ‘disgust’ is used to distinguish the middle classes from others. This, in turn, can act to position middle-class parenting practices as superior and prevent them from ever being judged as harmful. I join Lawler who suggests that it is important to ‘challenge and to go on challenging the assumption that middle-class dispositions, tastes and bodies are, by definition the “right” ones’ (Lawler 2005:443). Duncan (2005), in his work on class and mothering, draws on a remark by Ribbens-McCarthy and colleagues (2000:74) who suggest that ‘the content of the category [of class] remains in terms of people’s lived experience ... it is the category that is being dispensed with’ (cited by Duncan 2005). Health visitors’ accounts in this study suggest that the parenting practices in some families go unchallenged or are minimised through their own practices e.g. playing down mental health problems, being tentative about intervening in self harm, while in other families they become the focus of concern. Understanding the relationships between health visiting practice and class, I would argue, is an area in need of exploration and methodological development which moves beyond using dispensed with categories and realises a greater understanding of the lives of mothers with young children.

9.4 Evidence-base and health visiting practice

In Chapter 3 I explored the many and diffuse ways that evidence-base is shaping early years policy and health visiting practice. A theme throughout this thesis has been an exploration of evidence-base, first, in relation to Hall 4, and later in relation to health visiting work. It is

hard to argue with the premise of evidence-based practice (Goldenberg 2006). The density and morality of the position that practice should be based on 'good' and 'best' evidence has led to a number of approaches being taken within the health visiting profession, and the nursing professions more widely, to approach it in a way that could make their work and its potential benefits better understood. This includes the exploration of RCT evidence to support practice (Cowley and Bidmead 2009), systematic analysis of literature on, for example, intuition as evidence-based care (Welsh 2001), and measures to use the technologies of evidence-base to 'package' professional expertise and wisdom (Rycroft-Malone, Seers et al. 2004), or through suggesting alternative approaches to the evaluation of health visiting practice (Elkan, Blair et al. 2000). Each of these, in different ways, takes up the effectiveness agenda and attempts to demonstrate the value of health visiting work. In conjunction, recent texts of health visiting practice dedicate large sections to analysing (and resisting) the evidence-based movement (e.g. Luker, Orr et al. 2012). The emergence of these teaching texts would suggest that evidence-base, then, is not only about current practice, but about the future practice of the health professions, including health visitors.

Critiques of evidence-base, in particular evidence-based medicine (EBM) have highlighted features of concern among health professionals. These include the loss of professional autonomy, lack of opportunity to tailor interventions to individual needs, its use as a managerial tool in resource allocation, its potential to standardise effectiveness *and* quality, and that not all diseases and interventions can be studied by RCT with some interventions being far more amenable to this form of study, such as new drug treatments (Lambert, Gordon et al. 2006). Equally, evidence-based policy-making has been the subject of similar critique where Sanderson (2002:1) has suggested that the piloting of interventions has increasingly become a form of 'prototyping'. He suggests that a shift is necessary to policy being based on long-term evaluation (Sanderson 2002:1).

The relationship between risk and evidence-base, both themes in this study, is worth noting. Just as risk, it has been argued, is about bringing certainty into an uncertain world (Beck 1992), evidence-base, it has equally been proposed, is 'largely an effort to manage the

unruly social world' (Goldenberg 2006:2630). Such efforts, however, Goldenberg (2006: 2630) suggests:

... tend to disguise political interests in the authority of so-called "scientific evidence". The configuration of policy considerations and clinical standards into questions of evidence conveniently transform normative questions into technical ones. Political issues are not resolved, however, but merely disguised in technocratic consideration and language.

Evidence, then, becomes 'an instrument of, rather than a substitute for, politics' (Goldenberg 2006:2630). Given this view, understanding Hall 4, which its authors suggest is about 'best buy' options based on available evidence, can be opened up for critical analysis (Hall and Elliman 2006:23). Equally, the process of Hall 4 being implemented at a local level in Scotland necessitates a close analysis of the processes (and policies) through which this process is filtered. If we consider Hall 4 as purely a question of best evidence then some of the recommendations (e.g. around screening tests) may make good sense to the majority of those involved in its implementation. If, however, we consider Hall 4 more widely as part of a political process (e.g. a response to a national shortage of health visitors, resource limitations, changes to the welfare state, an emphasis by governments on preventative spend), then the consternation and resistances of the health visitors, evident in this study, become more understandable.

The answer lies, perhaps, not in rejecting evidence-base but to take a critical stance on it. Oakley (1998) argues in relation to the 'paradigm argument' that dichotomies of knowing are a 'historical and social construction'. She points to dualisms underpinning paradigm debates:

It became clear that the dualism of quantitative and qualitative is paralleled by others: hard/soft; masculine/feminine; public/private; rational/intuitive; intellect/feeling; scientific/artistic; social/natural; control/understanding; experiment/observation; objective/subjective; separation/fusions; repression/expression; autonomy/dependence; voice/silence ... (Oakley 1998:709).

There is a temptation to connect evidence-base and patriarchy, where, as Oakley (1998), suggests, there is a danger of describing ways of knowing as masculine/feminine. She

suggests we should guard against these dichotomous distinctions which could become a tool for discrimination rather than offering emancipation:

The result is likely to be the construction of a “difference” feminism where women are described as owning distinctive ways of thinking, knowing and feeling, and the danger is that these new moral characterizations will play into the hands of those who use gender as a means of discriminating against women ... the more we speak the language of “the paradigm argument”, the more we use history to hide behind; instead of looking forward to what an emancipatory (social science) could offer people’s well-being ... (Oakley 1998:731).

It has been argued that there is a need for a substantial development in the theoretical and research base of health visiting (Cowley and Bidmead 2009; Bunn and Kendall 2011). Such has been the pressure of the current evidence-based movement for health visiting that responses from within the profession can often seem defensive. I would argue that the health visiting profession could do well to work with the gender relations which shape its work and develop ways to evidence what health visiting practice ‘is’ over responding to critiques of what it is ‘not’. Recognizing that evidence-base is socially and culturally situated, fluid and changing, would be a progressive step. This move would allow professional groups, such as health visitors, to make their own contribution to defining its evidence-base.

9.5 The health visiting profession in the aftermath of Hall 4

So, where does this leave the health visiting profession itself? The study findings suggest that Hall 4, as well as impacting on practice, has challenged the health visiting profession as a whole. Listening to the expressions of the health visitors who took part in this study there was a palpable sadness. Wider discussions through the course of this research and reading of the literature, particular in practice journals such as *Community Practitioner*, suggest that this was part of a more global expression of demoralisation within the health visiting profession after the introduction of Hall 4.

Dingwall (2010), in his recent essays on the professions, draws on his PhD work from the 1970s which focused on health visiting training and how health visitors ‘accomplish profession’ through comparison with other profession groups, for example, doctors and

social workers. The observation that health visitors work, in their accounts, to establish their own area of expertise as different and ‘better than’ these other groups is one aspect of this concept that was evident in this study. This finding suggests that health visitors’ resistance to both the medicalisation of their work (Cowley, Mitcheson et al. 2004) and shifts in its emphasis towards social work are about establishing demarcated ground for their profession. This provides a useful marker in terms of our understanding of health visiting as a profession and allows us to see why it is necessary to conceptualise changes to health visiting practice since Hall 4 within the context of ‘profession’. Exploration of the relationship between health visiting as a profession and their everyday practice and role in policy implementation is also necessary in order to reveal the particular contemporary contexts within which health visitors are currently working. For this, I turn to the work of Lipsky (1980, 2010) and Powell and Gilbert (2007).

Lipsky’s concept of ‘street-level bureaucracy’, first published in 1980 and revisited by Lipsky for the 30th anniversary of the publication of his work in 2010, has proved a popular analytical tool for those exploring the relationships between professional groups and policy implementation (Hjörne, Juhila et al.; Wastell, White et al.; Lipsky 1980, 2010). Lipsky (1980, 2010) suggests that, despite good intentions of going into a job of public service, routines and mass processing become necessary due, primarily, he argues, to resource constraints. He explores how ‘unsanctioned work responses of street-level bureaucrats combine with rules and agency pronouncements to add up to what the public ultimately experience as agency performance’ (Lipsky 1980, 2010:xii). There were, of course, frequent examples of these practice moves in this study. In Chapter 8, for example, I discussed how health visitors spoke of taking measures to ameliorate the effects of their practice for ‘vulnerable’ families, by mediating what they reported on computer databases. An example given by HV4 was writing ‘social factors’ over ‘drug use’ to prevent terms such as ‘drug-abusing family’ from being generated and logged on the database. In conjunction, health visitors would resist treating their population of families through the lens of child protection and targeting by emphasising their motives for the work as being about nursing, caring, public health and all families. The tools they use, however, inevitably start to shape their ‘gaze’ (Foucault 1977) and how they understand and interpret families’ lived

experiences. The focus on risk and identifying the potential for future happenings within families brings with it a deficit model of parenting which sees parents as potentially lacking. The 'good enough' parent becomes an unachievable goal for those unlucky enough to become the focus of surveillance.

The social landscape which health visitors in their work with children and their families inhabit is, of course, complex. At the same time as being charged to ensure that children are protected, they likewise work to ameliorate the impact that a child protection agenda has on families, for example, the use of what HV6 described as 'bald statements' such as 'nice warm home, feeding well etcetera', which, at the same time, contradict the essence of their work and judgements about nuance and close observation. Lipsky's 'street-level bureaucracy' is useful in terms of thinking about health visitors as policy implementors and how children and their families experience the performance of the health visiting service. This said, I would argue that it provides a bleak reading of the situation where under-resourced staff have to improvise and standardise in their work with children and families and either burn out or reach some form of middle way where they can continue their work.

This pessimistic outlook, although visible in the research, I would suggest, does not wholly explain the research findings. Butler's concept of *performativity* may perhaps be more useful in doing this. Central to the concept of performativity is the idea that speech acts are closely aligned with power and are an act in themselves. Butler (1993:225) explains, 'Performative acts are forms of authoritative speech; most performatives, for instance, are statements that, in the uttering, also perform a certain action and exercise a binding power' (cited by Powell and Gilbert, 2007:194). The example Butler uses to introduce the idea is; 'I name this ship ...' which is, at the same time, 'the announcement and description of the act *and the act itself*' (cited by Powell and Gilbert 2007:194). Powell and Gilbert (2007) use Butler's performativity in their explorations of social work practice. The contesting of the boundary between health visiting and social work in the health visitors' accounts in this study would suggest that what is happening in social work theory could also be relevant for health visiting.

Powell and Gilbert (2007) draw on Fournier (1999:285), who clearly articulates that:

Professionals are both the instrument and the subject of government, the governor and the governed.

In conjunction, by drawing on Fleming's (2005) analysis of resistance to managerialism in contemporary post-industrial workplaces, they suggest that:

... actions such as cynicism, irony, humour and scepticism, once seen as a defence of selfhood, provide a more important function as they create a subjective space through which selfhood is produced (Powell and Gilbert 2007:199).

If this is the case, the health visitors' use of sarcasm and cynicism in their responses to Hall 4 (e.g. 'since Hall 4 has brought in his wonderful ideas of no contact' HV1) were serving a purpose for health visitors as they worked to incorporate the recommendations of Hall 4 through their practice and to rationalise its impacts for them, personally and professionally.

Further, the 'procedural arrangements', which focus on risk, set out in early years policy, for example, Hall 4, GIRFEC and the Early Years Framework, are operationalised through the practices of the early years professions, including health visiting. This is the space where a focus on risk and professional practice converge:

Professional status and expertise is located within embedded social practices and specific forms of performativity concerned with the identification and management of risk ... (Powell and Gilbert 2007:197).

This would suggest that the discourse of risk which has moved into health visiting practice is closely aligned to how health visitors, to borrow Dingwall's (2010) term, 'accomplish profession'. There is also an alignment between Butler's concept of performativity and Ahmed's (2004) collective feeling as bodies (and emotions), as well as speech, act in the (re)production of the relationships between (good) parenting and health visiting practice (Butler 1990). The picture emerging and to which these theoretical perspectives contribute provides little evidence of scope for the possibility that individual agency within health visiting can bring about change. However, it may be that there is room for optimism, as, alternative performances are possible, where:

... one performance complies with procedural requirements while a second performance opens space for the production of a resistant self, providing a degree of

stability in contexts of instability, flux and discontinuous change (Powell and Gilbert 2007:199).

Professionalism, Powell and Gilbert (2007: 200) suggest, is as always ‘enacted and performed’, and with this performance, comes opportunities for subversion. This reflects the work of Ceci and McIntyre (2001) discussed in Chapter 5. They highlight that ‘subjugated knowledge’ could play a vital role in allowing health professionals to be both rational practitioners, maintaining a coherent self, and at the same time to have grave doubts over the direction of travel of their practice and profession. This could also explain why health visiting appears to be weathering the storm as policy directives over a decade have attempted to change their role and function. It may well be that subjugated knowledge could have a critical role to play in the (re)formation of their work with all children and their families and the (re)defining of vulnerability through health visiting practice (Ryles 1999; Bradbury-Jones, Sambrook et al. 2008).

To re-iterate, alternative performances to those shaped by risk and judged through the prevailing ideals of evidence-base may, then, be possible. Goldenberg (2006) has drawn to our attention to how, despite its scientific veneer, evidence-base is a political process. New forms of evidence-base generated through health visiting practice and from within the health visiting profession may be possible. These would be generated through an ‘epistemological base of everyday knowledge’ grounded in ‘the dailiness’ of the lives of women and their families at the heart of health visiting practice (Edwards and Ribbens 1998:11). Through this process, a rejuvenated health visiting workforce and profession who have played a part in (re)defining understandings of vulnerability could emerge.

9.6 Methodological considerations and future research

Fox (1999:190) promotes the idea of ‘nomadic research’ where ‘knowledge is local and contingent’ and where the setting of a research aim, choosing of methods and analysis are part of an ongoing process of engagement. I join with his thoughts on nomadic research which, he suggests, is about ‘taking a situation and “thinking upside-down” (Handy 1991), recognising possibilities and novelty’ (Fox 1999: 199). My aim at the outset of this study was to explore how Hall 4 had been experienced by health professionals and all families

with young children. In doing so, I adopted a methodology which would allow me to explore and bring meaning to the experiences of both health professionals and families themselves. The process of engaging with professionals working in the field of early years was mediated by the ethics process. McAreevey and Muir (2011:391) have highlighted how 'the unquestioning adoption of a medical model of ethical review based upon positivist methodological assumptions has created many a mismatch between their ongoing ethical research practice and the process of obtaining clearance from Research Ethics Committees (REC)'. Although my study adopted an interpretivist approach from the start, I found that the confines of the ethical procedures forced me to think 'with' how health visitors and service users, in particular, were constructed through health visiting practice itself. This resulted in the representation of 'vulnerable' families in this research being revealed through the accounts of the health visitors and the mothers (families) present in the research. Hence, the absence of the families occupying this discursive space themselves in this research remains a limitation.

Similar to other studies around caring for young children, the majority of parents who took part in my study were mothers. Although my intention at the outset of this study was to involve fathers, I found that mothers were very predominantly the primary users of health visiting services. In conjunction, it was mothers to whom I was directed within families, even when both parents were present. Hence, fathers became understood through the accounts of the mothers who took part in the research rather than as service users in their own right. This was similar to how health visitors spoke about them in relation to their practice. From a methodological perspective, I believe that more complex understandings of the gendered relationships shaping health visiting practice would be possible if the fathers' views were present.

Fox (1999) suggests that intertextuality is a natural partner to reflexivity and that both are central to the process of representation. In this way, 'every text has an "inter-text" of related texts for the reader' and 'research texts, like any others, are to be read and re-read, not as representations (accurate or flawed) of the world, but as contested claims to speak "the truth" about the world, constituted in the play of the disciplines of the social' (Fox 1999:180). This thesis, for example, is an account of the implementation of Hall 4 with

many inter-texts generated through analysis of literature, policy and interview data. The absence of the voices of ‘vulnerable’ families and fathers remains a limitation of this research. It is not an unusual limitation, however, and, I would argue, that where the views of these groups are included in policy development, they remain peripheral to the process. Taking up Fox’s (1999) point about intertextuality, however, this is an issue in need of methodological consideration and prioritisation. While the voices of some groups remain absent, research may be inadvertently replicating assumptions about these groups which can limit policy.

Close attention to reflexivity in research is one way in which we can ensure that our analyses do not do so. Butler’s concept of performativity might also prove useful again. If we consider health visiting work as performance, which is strongly aligned to Butler’s concept of performativity, this has implications for methodology. If we consider that the relationships which shape the field are fluid and enacted rather than absolute processes of engagement, then it is possible to consider greater scope for engagement through health visiting practice. From this perspective, there could be an opening up of possibilities for engagement within research, too, with different users participating in different ways. Through thinking the research topic ‘upside-down’, the experiences of groups that are not using services or who are not the most predominant users could become known.

9.7 Policy and practice implications

The relationships between social and health inequalities across the life course are well established (Marmot 2005; Marmot 2006; Hertzman, Siddiqi et al. 2010). The importance of early intervention in mediating these has equally been the focus of influential reviews, for example, the Marmot Review (2010). The focus on the early years, however, although subject to an accumulating and strongly debated evidence-base, must also be understood within moral and political contexts where a focus on children and their development has potential to propel the health inequalities agenda forward.

The importance of the early years is permeating policy. This prominence is evident in policy in health, nursing and education, for example, in the Early Years Framework,

GIRFEC and with the Modernising Community Nursing Board's focus on early years work in community nursing. An example from education is in the national guidance, 'Pre Birth to Three: Positive Outcomes for Scotland's Children and Families' (2010e). However, it is not the policies themselves, but how the 'procedural arrangements' (Powell and Gilbert 2007) within these and other policies have been translated into practice and have become practice, through and in the aftermath of the implementation of Hall 4, which has been the focus of this thesis.

Debates around universalism and targeting in the early years are evident in policy and practice. The meaning of and relationship between universalism and targeting, however, is often ambiguous as this extract from the Early Years Framework (2012) suggests:

The Early Years framework acknowledges the power of universal services in securing better outcomes for children is key. However, there is a need to strike the balance between universal and targeted services. The taskforce recognises the importance between universal and targeted services at supporting vulnerable children and their families. While we need to focus provision on where it is needed most, we must also ensure that universal services can deliver effectively for the more vulnerable (Scottish Government 2012c:4).

The Marmot Review recommends 'proportionate universalism':

To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, but focusing solely on the most disadvantaged will not reduce the health gradient, and will only tackle a small part of the problem (Marmot 2010:16).

The term 'proportionate' is used throughout the report and strongly emphasises the need for greater intensity of action towards the most disadvantaged, for example, those in early years education. At the same time, the Marmot Review highlights the importance of universal programmes of health in the early years. The Review is unequivocal in prioritizing the importance of the early years and its potential to bring about health equality:

We are therefore calling for a "second revolution in the early years", to increase the proportion of overall expenditure allocated there (Marmot 2010:22).

There is little evidence, however, of resources being allocated to this in Scotland. In the recently published Scottish Government document ‘A New Look at Hall 4 – the Early Years – Good Health for Every Child’ (Scottish Government 2011c), the introduction of a 24-30-month child health review is proposed. Recent guidance on the implementation of this programme have been now been drafted (Scottish Government 2012a). No additional resources have been allocated nationally, although NHS Boards can choose to focus spending on this area. While this remains the case, it is likely that risk will continue to shape and dominate health visitors’ work with vulnerable families (Parton 1998). The new guidance does, however, recognise that contact with children and families is necessary beyond the first weeks after a baby is born and may provide health visiting with opportunities to re-establish their practice and their work as a profession.

This recognition could provide an opportunity for the ‘*making*, rather than taking’ (Aranda and Jones 2008:8) of health visiting roles, allowing for a different way of reading the profession. It may, I have argued, be unhelpful to think of health visiting work through the lens of evidence-base where it is constructed largely as lacking in effectiveness. Rather, if we explore the historical development of health visiting work, we begin to understand the social relations of health visiting practice. Despite uncertainty over its present and its future, the observational and relationship work with families and with other professionals remains a constant aspect of health visiting practice (Davies 1988; Cuesta 1994) from which their public health mandate emerges (Craig and Smith 1998). There may be alternative ways to prove effectiveness, an understanding of which could contribute to the development of more sensitive mechanisms for use in evidence-base work. The health visitors’ accounts in this study suggest that it is through the groundswell of working with children, mothers and families and the ‘dailiness’ of their lives that knowledge and expertise are generated. It is this, in turn, which has the potential to make health visiting strategic, in contrast to, as has been suggested, operating through a predefined public health agenda (Brocklehurst 2004). It is this, I would argue, which makes for ‘effective’ practice in health visiting, which has contributed to its longevity as a profession, and which now requires closer examination.

At the same time, the findings of this research suggest that there is a need to shift the focus of policy and practice from children and child protection to relationships between children, their families and parents. There are many ways in which this is need could be operationalised in policy and practice at local and national levels. For example, the Early Development Instrument which has been piloted in East Lothian in Scotland has shown the potential for increasing awareness of the early years at a community level providing a basis for communication within communities about solutions and resource allocation to meet the needs of all children and families (Geddes, Woolfson et al. 2011).

9.8 Concluding thoughts

The dual constructs of evidence-base and risk suggest a desire for certainty in modern society. As Lupton highlights, however, ‘ontological uncertainty, ambivalence and fragmentation need not be negative’. She draws on Smart (1993:103), who says:

... the prospect of living without certainty or necessity may cause us to respond with fear, anxiety, and insecurity, but equally it allows us to live with imagination and responsibility ... It constitutes a site, space, or clearing for political possibilities, rather than a distinctive political strategy (Smart, 1993:103, cited by, Lupton 1995:161).

What if we were to put to one side political strategy and use the clearing that Smart refers to where we consider ‘political possibilities’? What then would health visiting practice and services for families with young children look like? In this technocratic age, the possibilities for developing critical thinking around how we care for our children are as many as we allow ourselves to imagine, each of which will flourish when the relationships between children, their families and professional groups are cared about and brought centre stage.

Marmot (2010) called for proportionate universalism and a focus on the early years in order to address health inequalities. Although the Marmot Review’s terms of reference were for England, the sentiment of the Review has been widely adopted in Scotland also. Marmot (2006, 2010) brought to our attention that health inequalities are not inevitable and he has provided us with a compelling argument of why this is the case. This study suggests that existing approaches to health visiting work with children and families are unlikely to

contribute in any substantial way to these health equality goals. A universal health visiting service which can be reflexive and define its own parameters of effectiveness could be one way to progress. There are others, too. Involving children and their families in decision-making about their health and well-being will be crucial. It will require for each policy and strategy to focus on the connectedness and the relationships between individuals, families and communities if the goal of Health for All Children is to be achieved.

Epilogue: The making of the film ‘Targets’

Whatever we know, we know from the world that surrounds us. Art studies the world, in all its manifestations, and renders back to us not simply how we see, but how we react to what we see and what we know as a consequence of seeing. The world is the source of all of our relationships, social and political as well as aesthetic. Art is part of the world, not apart from it. (White 2011)

Introduction

My ESRC CASE studentship provided me with an opportunity to explore how a new policy context has shaped the practices of health visitors and their relationships with families with young children. In Chapter 4 I drew on the work of Lomas (2000) to highlight that, as I would also argue, research and policy are processes rather than one-off products. With this in mind, I turn now, in this epilogue, to discuss the development of the film ‘Targets’ which aims to act as a stimulus for critical thought on policy and practice in the early years. I contextualise the film by, in brief, considering knowledge exchange where I position the knowledge generated through research alongside knowledge generated through policy and practice processes. I then discuss the collaboration between research and art in knowledge exchange (through researcher and artist), before finishing with a brief description of the film itself.

Knowledge exchange

It has been suggested that an emphasis on evidence-based practice over other forms of knowledge and learning, from personal experience or teachers’ experience, has acted to limit the adoption of research in practice (Fox 1999). Fox (1999), drawing on Wood and colleagues (1998), suggests that there is a need to connect research with ‘locally situated practices’ where any “research findings” represent not so much truth about reality, as a reified moment in an ongoing and indeterminate process’ (Fox 1999:197). In conjunction, he brings to our attention the importance of considering the ‘big picture’ over individual research findings (Fox 1999) for research to become relevant to the work of policy-makers and practitioners.

Using art in knowledge exchange

The film 'Targets' was developed in collaboration with Rosie Gibson, CRFR Artist in Residence (2008-2009). Rosie and I collaborated at first to develop ideas on involving 'vulnerable' families in the research. In 2009 I received funding through success in a poster presentation competition at the Knowledge Transfer Scotland: Policy and Practice Conference at Heriot-Watt University. This enabled the film 'Targets' to be made, through which the findings of the research are explored. The process of making the film provided me with a mechanism to bring the themes of my analysis together into an analytical story about health visiting and mothering practices since the implementation of Hall 4. The film, in turn, provides an opportunity to take a trans-section of that story and to use art to 'render back' the analysis (White 2011) for the purpose of engaging in knowledge exchange work. It is aimed, in particular, at policy and practice audiences with an interest in child health.

Making the film 'Targets'

An acknowledgement of the value of close observation is the guiding principle of the film. Rosie and I, through our collaboration, realised that this shaped both her practice, as an artist, and my own, as a researcher. In conjunction, the research findings suggest that this is also a central aspect of health visiting and mothering practices. The main visual image used in the film is of a baby being held by his mother and drawn by Rosie. Rosie's close observation of the baby through drawing him provides a backdrop for a dialogue about vulnerability. The three characters who engage in this dialogue are a health visitor, mother and researcher. The film aims to work affectively and uses the voice of the mother to express how vulnerability can be part of every mother's experience. The health visitor tells the story of how her practice has changed post-Hall 4 and is increasingly focused on families who are deemed 'risky' over all families. It picks up on how reassurance and encouragement play a central role in enabling parents to care for their babies. My voice, as researcher, provides the analytical story about vulnerability exploring how when vulnerability is understood as solely about risk, some mothers who need support go without, while others may resist it. Paradoxically, the act of focusing and targeting health visiting services in on families inadvertently pushes families to the outside. The message this gives is that they are less than 'good enough' in their endeavours to care for their children. This,

in turn, can act to marginalise and stigmatise families. The name of the film, 'Targets', alludes to whether the practices of some families and health visitors have become the targets of scrutiny and criticism through policy which aims to improve children's health and well-being. I plan to use the film as part of a programme of knowledge exchange work based on this thesis.

Appendices

Appendix 1: Information Leaflet: Health Professionals

Thank you for taking time to read this. If you are interested in taking part in the study or have any further questions before deciding, please contact me by phone, e-mail or letter.



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Before deciding if you want to take part please take time to read the following information about why the study is being done and what it would involve for you.

What is the purpose of the research study?

Health for All Children 4 (Hall 4) and guidance for its implementation in Scotland were published in 2003 and 2005 respectively. This study aims to explore the implementation of Hall 4 in Edinburgh and across Lothian and to examine the extent to which the targeted approach to the provision of health care proposed by Hall 4 is meeting the needs of all families with young children.

Who will take part in the research study?

If you are a health visitor, general practitioner, midwife, health manager, or other early years' professional you may be interested in taking part.

Mothers, fathers and carers who have a child who is 2 years or under will also take part in the research study.

Do I have to take part?

It is up to you to decide. I will discuss the study with you and give you the opportunity to ask questions. I will then ask you to sign a consent form to show that you have agreed to take part. You are free to withdraw, at any time, without giving a reason. The decision to participate or not is entirely yours and your manager will not be informed either way.

What will happen if I decide to take part?

If you decide to take part it will involve two interviews with a Researcher, Caroline King, around 12 months apart. The interviews will take around 1 hour each and take place at a time and venue which is convenient for you. If you have to travel to this place, costs can be reimbursed.

The interview will be qualitative, rather like a 'guided conversation'. The interview is to find out about your views and experiences. In the course of the interview I will be interested in hearing about the successes, challenges and difficulties of providing health care for

Health for All Children:

How professionals and parents experience the implementation of Hall 4



In your role as a health professional you are invited to take part in a research study about providing health care for children in Edinburgh and across Lothian.

The research is a partnership between Public Health in NHS Lothian and the Centre for Research on Families and Relationships (CRFR). It is a PhD study funded by an Economic and Social Research Council (ESRC) CASE studentship.

children and families in your area. In the second interview we will discuss any changes you have experienced since we first met. As a Researcher, I am interested in finding out about practice from the point of view of those directly involved. I am, however, not in a position to judge it, and will not do so.

In writing up the research I will be looking for experiences which are similar as well as different. The final report will provide an account of these 'themes' which will be illustrated by quotes from people who have taken part in the research. After the interviews are completed, you will receive a newsletter to provide feedback about the study and the preliminary findings.

Are there any benefits from taking part?

It is hoped that you will enjoy the opportunity to discuss what works well and what difficulties you have experienced in meeting the needs of children through the targeted approach to health care provision advocated by Hall 4. This will contribute to knowledge in this area to allow for good practice to be shared and difficulties to be addressed.

Are there any possible disadvantages of taking part?

If you have any concerns about taking part in the research there will be an opportunity to discuss these prior to the interviews. If you feel you want to stop the interview, you can do so at any time temporarily or completely.

Will everything I say be kept confidential?

We will discuss how best to make a record of the interviews. This can be done by using a recorder or taking notes. The recordings or notes will be typed up. These will be kept confidential and stored securely. The information will be kept until the project is completed and written up. It will then be disposed of securely.

In writing the research reports your name and the place that you work will not be identified. I will also make sure, as far as is possible, that any other information which may enable you or another person to be identified is anonymised. It is likely that anonymised data from this and other interviews will be discussed with my named Supervisor.

Appendix 2: Information Leaflet: Families

Thank you for taking time to read this. If you are interested in taking part in the study or have any further questions before deciding, please contact me by phone, e-mail or letter.



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Before deciding if you want to take part please take time to read the following information about why the study is being done and what it would involve for you.

What is the purpose of the research study?

In 2005 changes were made to how health visitors and other professionals work to provide health care and promote the health of children and families. These changes are referred to as Health for All Children 4 (Hall 4) and have taken place in Lothian and across Scotland and the United Kingdom. The aim of this research study is to find out which changes are working well and what could be developed.

Who will take part in the research study?

If you are a mother, father or carer of a child who is 2 years or younger you may be interested in taking part. You do not need to have specific good or bad experiences to share, just an interest in talking about the health care you have received for your child.

Health visitors, general practitioners, health managers, and other early years' professionals will also take part in the research study.

Do I have to take part?

It is up to you to decide. I will discuss the study with you and give you the opportunity to ask questions. I will then ask you to sign a consent form to show that you have agreed to take part. You are free to withdraw, at any time, without giving a reason.

Your GP will be informed of your participation in the research study with your permission. The purpose of this is so that she or he is aware that the research study is taking place. Taking part or not will not affect the current or future care of you or your child.

What will happen if I decide to take part?

If you decide to take part it will involve two interviews with a Researcher, Caroline King, around 12 months apart. The interviews will take around 1 hour each and take place at a time and place which is convenient for you. If you have to travel to this place, costs can be reimbursed.

The interviews will be like a 'guided conversation'. In the first interview

Health for All Children:

How professionals and parents experience the implementation of Hall 4



As a mother, father or carer of a child who is 2 years or under you are invited to take part in a research study about the health care of children in Edinburgh and across Lothian.

The research is a partnership between Public Health in NHS Lothian and the Centre for Research on Families and Relationships (CRFR). It is a PhD study funded by an Economic and Social Research Council (ESRC) CASE studentship.

you will be asked about the health care you have received for your child and what other information, advice or support would have helped. In the second interview, we will talk more about your experiences since the first interview. I will be interested in hearing about your experiences and point of view in your own words.

In writing up the research, I will be looking for experiences which are similar as well as different. The final report will provide an account of these 'themes' which will be illustrated by quotes from people who have taken part in the research. After the interviews are completed, you will receive a newsletter to provide feedback about the study and the preliminary findings.

Are there any benefits from taking part?

It is hoped that you will enjoy the discussions, and the opportunity to contribute to research which aims to improve the health care which is provided for children and families.

Are there any possible disadvantages of taking part?

If you have any concerns about taking part in the research there will be an opportunity to discuss these prior to the interviews.

If, when you are talking about experiences relating to the health care you have received for your child, you feel you want to stop the interview, you can do so at any time temporarily or completely.

Will everything I say be kept confidential?

We will discuss how best to make a record of the interviews. This can be done by using a recorder or taking notes. The recordings or notes will be typed up. These will be kept confidential and will be stored securely. No personal information will be shared with anyone else (other than in exceptional circumstances if there is a concern that a child or other person is at harm or risk of harm). The information will be kept until the project is completed and written up and will then be disposed of securely.

In writing the research reports your name and the place that you live will not be identified. I will also make sure, as far as is possible, that any other information which may enable you or another person to be identified is anonymised. It is likely that anonymised data from this and other interviews will be discussed with my named Supervisor.

Appendix 3: Consent form: Health Professionals

**Health for All Children:
How professionals and parents experience
the implementation of Hall 4**

Researcher: Caroline King

	Tick as appropriate	
	Yes	No
1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	<input type="checkbox"/>	<input type="checkbox"/>
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	<input type="checkbox"/>	<input type="checkbox"/>
3. I am happy for the interview to be audio recorded.	<input type="checkbox"/>	<input type="checkbox"/>
4. I agree to take part in the above study.	<input type="checkbox"/>	<input type="checkbox"/>

Name of professional

Date

Signature

Name of researcher

Date

Signature

Appendix 4: Consent Form: Parents/Carers

Health for All Children: How professionals and parents experience the implementation of Hall 4

Researcher: Caroline King

	Tick as appropriate	
	Yes	No
1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	<input type="checkbox"/>	<input type="checkbox"/>
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my health care or the health care of my child being affected.	<input type="checkbox"/>	<input type="checkbox"/>
3. I am happy for the interview to be audio recorded.	<input type="checkbox"/>	<input type="checkbox"/>
4. I agree to take part in the above study.	<input type="checkbox"/>	<input type="checkbox"/>
5. I give permission for my General Practitioner to be informed of my participation in this research study.	<input type="checkbox"/>	<input type="checkbox"/>

_____	_____	_____
Name of parent	Date	Signature

_____	_____	_____
Name of researcher	Date	Signature

Appendix 5: Interview Guide: Parents/Carers

Research title: Health for All Children: How professionals and parents experience the implementation of Hall 4

Note: The interviews will be semi-structured. The areas specified in this interview guide provide an outline of topics which will be discussed. As with all qualitative research, the exact phrasing of questions will vary between interviews, but they will always be open-ended, allowing the respondent to express themselves in their own terms.

Aims of the interview

To explore the experiences of health care and support received by parents/carers for their child and family

To explore this within the context of Health for All Children 4

To enable parents/carers to discuss their views openly and in-depth

Section 1: Starting the interview

My name is Caroline King, I am a PhD Researcher based at the University of Edinburgh. Today I'm interested in talking to you about the health care and support which your child has received since and before she/he was born.

Before we start, I'd like to discuss the following:

What will happen in the interview – the approach and the type of questions

How we record the interview

If either of us needs to stop the interview, how we can go about it

What will happen with the information collected in the interview afterwards – that is, how it will be made anonymous and how it will be reported

Consent for participation in the interview / research

Section 2: Background information

Before we start the main interview I have some questions to ask about your family and your circumstances. These provide helpful background and contextual information. It is helpful for me to have answers to all these questions. If however, there is one or more which you do not want to answer that is fine.

Questions on:

Number of adults in household

Relationship of primary carer to each of these adults

Number of children in household

Number of children outside of household

Employment status of primary carer and any other adults in household

Household income (using a response card)

Section 3: The main interview

Section 3a: Child and family health and well-being

What I'd like, first of all, is to find out more about your day to day experiences of looking after your child and his/her health. I'm interested in hearing about your experiences, in your words. To start then, could you tell me about what is important for you when it comes to looking after the health of (child's name) on a day to day basis?

Prompts/probes

In the longer term, what is important when it comes to looking after the health of (child's name)?

What does the term 'good health' mean to you? What does the term 'good health' mean to you, in relation to (child's name)?

What measures do you take to keep healthy? What measures do you take to keep (child's name) healthy?

Do you find it easy to keep healthy? If yes, what helps you to keep healthy? What gets in the way of keeping healthy?

Do you find it easy to look after the health of (child's name)? If yes, what helps you to keep (child's name) healthy? What gets in the way of keeping (child's name) healthy?

Are there times as a parent/carer which you have found particularly rewarding?
Could you tell me about them

With the ups and downs of looking after a child, are there times as a parent/carer when you have had to really draw on your reserves to get through?
Could you tell me about them

What are you most proud of in looking after (child's name)'s health?

As a mother, father or carer, what do you think are your particular strengths which you draw upon when looking after (child's name) and (child's name)'s health?
Are there any areas of child health care which you find difficult?

What has worried you the most so far in bringing up (child's name)?

What has caused you the most stress so far about bringing up (child's name)?

Section 3b: Experience of health care and support

I'm interested now in hearing about your experiences of the health care and support which you have received for your child. Can you tell me about the contacts which you have had with health services or health professionals about (child's name)'s health?

Prompts/probes

Which health professionals have been to your home?

Which health professionals have you taken (child's name) to?

What happened before you had (child's name)? (ante-natal care)

Which health professionals did you see?

What did the appointments/contacts involve?

What was your experience of them?

When did you first meet with your health visitor?

What was it like?

How often do you see your health visitor these days?

Where do you see your health visitor? Is it at home? At groups? At clinic appointments?

Do you see her/him enough? If not, how often would you like to see her/him?

How do you decide when you need to see your health visitor?

Are there times when your health visitor decides she/he needs to see you?

What do you talk about when you see your health visitor? Tell me only what you feel happy sharing.

Do you feel you can contact your health visitor at any time you need to?

What is your relationship like with your health visitor?

What is the relationship between your health visitor and (partner's name) like? (if relevant)

How do you find your health visitor and (child's name) relate to one another?

Have you found that your own relationship with your health visitor has changed over time?

If you imagine the best possible relationship between you and your health visitor – how would you describe it?

What, of all we have discussed so far, has been the most helpful?

Have there been any times when (name of child) has experienced particular episodes of ill health or been not so well?

I'm interested in hearing about both ill health which has turned out to be fairly minor and/or has passed as well as more serious conditions which have either passed or have longer term implications for (name of child)'s health

Can you talk me through what happened when (name of child) wasn't well?

What did you find useful in this situation?

Have you found that the health 'needs' of (name of child) have changed over time?

If yes, in what way have they changed?

As the health needs of your child have changed, have you found that you have been able to get advice/support on an on-going basis?

Are there any other 'support' services which you and / or (name of child) receive which you have been referred to by your health visitor / another health professional?

- If so, could you tell me about them?
- What has been your experience of using these services? - Do you feel (name of child) has benefited from these services?
- Do you feel you have benefited from these services being put in place?
- What in your view makes for a 'good' service?

How do you feel the support has been for you in relation to (name of child) compared to your older children (if relevant)? (i.e. pre and post Hall 4 implementation)

Some people (like yourself) see a lot of health professionals when they have a child. Could you tell me about a time when you feel that the health professionals you have seen have worked particularly well *together* to provide support/advice for you/(name of child)? (if relevant)

Sometimes it can be helpful and/or necessary for health professionals to share information about a child in order to make sure that his/her health is being cared for appropriately. I'm interested in your view on this.

Have you experienced any circumstances when you think that sharing information about (name of child)'s health has been / or would have been helpful?

If yes, could you tell me about them?

What information (if any) do you think it is useful for health professionals to share?

Equally, is there information which you think should not be shared?

If yes, are there times when you think it would be appropriate to share this information?

Are there any other people you have found useful for advice/support in relation to (name of child)'s health?

Do family provide advice/support? If so, in what way?

Equally, do friends provide advice/support? If so, in what way?

And other people such as neighbours, do they provide advice/support? If so, in what way?

Are there any other sources of advice/support which you have used in relation to (name of child)'s health?

Have you ever used the internet for health advice in relation to (name of child)'s health? If so, how useful have you found it? How do you go about making sense of the information?

Have you ever used NHS 24 in relation to (name of child)? If so, what has your experience been of using it?

Are there any other sources of advice/support which you have used which we haven't discussed yet?

Section 4: Finishing off the interview

Are there any issues relating to the health and health care of (name of child) which we have not discussed yet that you would like to tell me about?

To finish off, I'd like to tell you a bit about what happens next and see if you have any questions you would like to ask me. Like we discussed at the start, I will now type up the

interview. When I do that I will make sure that the interview is made anonymous by taking out names and places where you or other people live, work or access health care, for example. I will then read all the interviews and go through a process of identifying the key themes between interviews and themes which are unique to individual interviews which are also important.

I will then get in contact, if you are happy for me to do so, a second time to discuss any changes which have happened since this first interview. This will be in around 10 to 12 months time. With the second interview, I will similarly type it up and identify themes and unique stories. The final stage is then to write up the interviews in a PhD thesis, other reports and for publication in academic journals.

Before we finish I would like to take a few minutes to review what has happened today and to ask if there are any points you would like explained or to ask about.

Can you tell me how you have found this interview?

How have you found the questions which I have asked?

What have you liked about the interview?

Is there anything which you think I could do to make it a better experience for people taking part?

Are there any questions, or concerns you have about the interview which you'd like to chat through? If you have any questions about the interview that come to mind afterwards that you want to contact me about, that is absolutely fine to do so. Make sure the respondent has contact details. Thank you very much for your time and sharing your experiences.

Appendix 6: Interview Guide: Health Professionals

Research title: Health for All Children: How professionals and parents experience the implementation of Hall 4

Note: The interviews will be semi-structured. The areas specified in this interview guide provide an outline of topics which will be discussed. As with all qualitative research, the exact phrasing of questions will vary between interviews, but they will always be open-ended, allowing the respondent to express themselves in their own terms. Some questions may not be appropriate for all health and early years' professionals interviewed. The interview guide will be adapted accordingly.

Aims of the interview

To explore the experiences of health professionals providing health care and support for children (and families)

To explore this within the context of Health for All Children 4

To enable early years' professionals, including health visitors, GPs and midwives to discuss their work openly and in-depth

Section 1: Starting the interview

My name is Caroline King, I am a PhD Researcher based at the University of Edinburgh. Today I'm interested in talking to you about the health care and support which you provide for children and their families.

Before we start, I'd like to discuss the following:

What will happen in the interview – the approach and the type of questions

How we record the interview

If either of us needs to stop the interview, how we can go about it

What will happen with the information collected in the interview afterwards – that is, how it will be made anonymous and how it will be reported

Consent for participation in the interview / research

Section 2: Background information

Before we start the main interview I have some questions to ask about your caseload, how your work is organised, and the families you work with. Responses will provide helpful background and contextual information.

Questions on (as appropriate):

Number of families in case load

Number of families currently allocated to each health plan indicator

Number of people in (health visiting) team

Posts of people in team

Individual or corporate case load

Number and type of clinics / group work / home visits carried out in a typical week/month

Section 3: The main interview

Section 3a: Health work with children and families

What I'd like first of all is to get an idea about your work and what it involves. Could you tell me, in your own words, about your work with parents/carers and their children? You might want to start by telling me about a 'typical' day or week, or by choosing an example to illustrate your work. I'd like to learn about your work and how you experience it on a day to day basis.

Prompts/probes

How many home visits would you do in any one week?

How many clinics?

How many groups?

What other activities are you involved in with your work with children and families?

When would a typical first contact with a child/family take place?

Where would it take place?

What would it involve?

Can you describe for me the best or ideal first contact you could envisage – what could this look like?

How are contacts after the first contact with parents/carers and their child decided upon?

Where would these take place?

How is the frequency decided upon?

What would they involve?

Who do you feel you relate to as the 'client'?

Is this the child, the parent/carer, or the wider family?

Are there any implications/challenges resulting from this?

Can you describe to me what you would feel to be your ideal relationship with parents/carers?

Does this differ between fathers and mothers?

What is your ideal relationship with the child(ren) in the family?

Do you find relationships vary between different parents/carers?

- If yes, in what way do they differ?

- Do you find that relationships change over time?

- If yes, in what way do they change?

Could you describe to me a parent/carer-health professional relationship at its best?

Could you give an example?

Have you experienced times when relationships haven't quite been as you would have liked?

If so, could you give an example?

In these circumstances, what measures might you take to improve the relationship?

What do the concepts of 'need' and 'needs assessment' mean to you?

As a health professional, what professional and personal skills/attributes do you draw upon when you are assessing a child / family's health (needs)?

Are there any tools which you use in your assessments?

Are you familiar with the Lothian Child Concern Model (LCCM)?

Is this (the LCCM) something you have used in your work?

If yes, could you tell me about your experience of using it?

What are the important elements of assessment as you see them?

Who would 'typically' be assessed as being in each of the health plan indicator categories of core, additional and intensive?

Do you find that the health needs of children and their families change over time?

If yes, what impact does this have on the way in which you work with children and their families?

In general, what health issues do you find parents/carers tend to raise?

And with regard to their child in particular?

How would you typically respond?

How do these compare with the health issues which you view important?

What are examples of the types of advice/support/services which you can provide for parents/carers and their families?

Are there other services which parent/carers and/or their children can use through being referred?

What to you would be markers of 'good' support/advice?

Equally, what do you think makes for a 'good' service?

Could you describe your best experience of working with children/families?

Could you describe a talent/skill/attribute which you bring to your work with children and families, which you feel makes a difference?

Section 3b: Changing roles and relationships with the implementation of Hall 4

How do you feel about your new role since Hall 4 has been implemented?

Prompts/probes

Are there benefits of working in this way?

If yes, what are they?

What are the challenges as you see them in relation to your new role (if any)?

In working with children and families in this new way, what are you aiming to achieve?

What is your perception of how parents/carers feel about the changes in how health care and support is provided for their children? (i.e. pre and post Hall 4 implementation)

How do you feel that relationships have changed between you and other members of the primary care team since the implementation of Hall 4?

Could you tell me about a time when you feel that the primary care team has worked particularly well together to meet the needs of a family?

What is your view on the documentation and sharing of information about the children/families with whom you work?

What would you view to be 'good practice' in relation to documenting information?

What would you view to be 'good practice' in relation to sharing information?

Section 3c: Health promotion

Thinking now about the broader health promotion aspects of your job, could you talk me through about some of the work you might typically do with children and families to promote their health?

Prompts/probes

Could you tell me a bit more about the different aspects/activities you have described?

What is one of your proudest achievements in relation to the health promotion work you do?

What enables the health promotion work you do?

What constrains the health promotion work you do?

What do you view the health issues to be in relation to the wider community with whom you work?

Do you view yourself to have a role in relation to these health issues within the wider community?

If so, in what way?

How do you find the health needs of the community sit in relation to the health needs of the individual families with whom you work?

Are there any challenges in working with both individual families and within communities?

Section 4: Finishing off the interview

Are there any issues relating to the health care and support which you provide for children and their families which we have not discussed yet that you would like to tell me about?

To finish off, I'd like to tell you a bit about what happens next and see if you have any questions you would like to ask me. Like we discussed at the start, I will now type up the interview. When I do that I will make sure that the interview is made anonymous by taking out names and places where you or other people live or work or names of health facilities,

for example. I will then read all the interviews and go through a process of identifying the key themes between interviews and themes which are unique to individual interviews which are also important.

I will then get in contact, if you are happy for me to do so, a second time to discuss any changes which have happened since this first interview. This will be in around 10 to 12 months time. With the second interview, I will similarly type it up and identify themes and unique stories. The final stage is then to write up the interviews in a PhD thesis, other reports and for publications in academic journals.

Before we finish I would like to take a few minutes to review what has happened today and to ask if there are any points you would like explained or to ask about.

Can you tell me how you have found this interview?

How have you found the questions which I have asked?

What have you have liked about the interview?

Is there anything which you think I could do to make it a better experience for people taking part?

Are there any questions, or concerns you have about the interview which you'd like to chat through? If you have any questions about the interview that come to mind afterwards that you want to contact me about, that is absolutely fine to do so. Make sure the respondent has contact details. Thank you very much for your time and sharing your experiences.

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